THE

CINCINNATI JOURNAL OF MEDICINE.

AUGUST, 1866.

ANATOMY, SURGERY, AND OPHTHALMOLOGY.

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ART. I.—*Exsection of the Head, Neck and Trochanteric portion of the Femur.* By GEO. C. BLACKMAN, M. D., Prof. etc. (Reported by GEO. W. HAILE, M. D., House Surgeon, St. John's Hospital.)

JNO. GLESON, aged 23 years, a native of Ireland, came to St. John's Hospital on the 9th of June, 1863. He was suffering from hip disease, stating that he joined the U. S. Army on the 12th of August 1861, and served under McClellan in Virginia, during the peninsular campaign. He was captured in one of the seven day's battles at Savage Station, and taken to Belle Isle, Richmond, on the 29th of June, 1862; where he was retained until the 20th of the following August, when he was exchanged. While there, he suffered from cold and hunger, and became very much reduced in flesh. There he felt the first symptoms of the hip disease, namely, a stiffness, accompanied by occasional pains in this region. After he was exchanged, he went to Philadelphia, where he remained until the 12th of January, 1863, when he was discharged. His general health improved while there for the first three weeks; his hip, on the contrary, became very much inflamed, and very painful, accompanied with some pain and stiffness at the knee. The leg assumed a semi-flexed position, from which it could not be moved without violent pain; he was treated then for rheumatism, but derived no benefit. About the fifth week he took

cold and suffered from a severe attack of bronchitis, accompanied by hemorrhage from the lungs to the amount of eight ℥. From this period, his general health began to decline; he became very much emaciated—expectorated large quantities of pus—suffered from night sweats—and was informed by his physician that he had tubercular deposit in his lungs. He remained in this condition until he was discharged, when he removed to New York city, where he was treated for the pulmonary difficulty, by which his general health was much improved, although there was no perceptible change in the hip disease. After remaining there four months, he removed to Cincinnati, and placed himself under the care of Prof. Blackman. For a while his whole condition seemed to improve; but in September following, his pulmonary difficulty became worse—the hemorrhage returned—expectoration became more profuse than before, and his whole system became very much reduced. He remained in this condition for about two months, his case being considered hopeless. At length his pulmonary difficulty began to improve, and with it his general health. At this period an abscess commenced forming at the hip joint, and gradually increased for thirteen months, when it had attained an enormous size. Pointing on the inner aspect of the thigh, it finally burst, discharging a large quantity of pus. His general health in the meantime remained very good under the use of iron, cod-liver oil and other tonics. A large number of small fragments of bone came out at the opening, and the abscess continued to discharge during the summer large quantities of pus. In the following August his hip became very painful; two large abscesses formed on the posterior aspect of the thigh in the gluteal region; he suffered from hectic, and became very much emaciated. On November 28th, 1865, Prof. Blackman opened the abscesses, which discharged large quantities of a thick greenish pus, and on the 5th of December, he exsected the head, neck, and about three inches of the shaft of the femur. The acetabulum was somewhat diseased also, but was not disturbed. He improved after the operations until the tenth day, when he had a violent attack of the cholera morbus, which threatened a fatal termination, but was finally checked by the use of appropriate remedies. His general health began to improve rapidly—his appetite became good; and under the use of wine, iron and a generous diet, the hectic symptoms disappeared. His limb was supported in the straight position by means of sand bags, and contracted gradually to the extent of three and one half inches. In four weeks after the operation, he was able to flex the thigh upon the pelvis; and in ten weeks he was able to walk on his crutches. During the

winter and spring he had occasional collections of pus form on the anterior aspect of the joint, which occasioned considerable pain until they were discharged. He has the power of flexing and of extending the limb; also of partially abducting and adducting it—and on this the 9th of July, 1866, we find his general health good. He sleeps well, has a good appetite, and the wound still keeps discharging pus to the amount of two or three ʒ per day.

Art. II.—*Extracts from Mr. Hutchinson's Lectures.*

Bromide of potassium in irritable conditions of the urethra.

During the last six months, I have, on the recommendation of a friend, a naval surgeon, made a rather extensive trial of bromide of potassium in cases of inflamed stricture. My friend's statement was that it even procured the absorption of recent strictures. Nothing is more difficult than to arrive at a satisfactory conclusion as regards a therapeutical question like this, but I may venture at any rate to say that the cases in which I have tried it (probably more than thirty) have all of them done remarkably well. In nearly all of them I was employing catheters at the same time, so that the result might be fairly attributed in part to the latter. In several, however, it was quite remarkable how rapidly a tight stricture yielded to dilatation. The remedy appears to render the urethra very much less irritable. Many of the patients spoke strongly as to their own impressions that it did good in this direction. I will not theorize on its action, but we may suitably remember that an allied salt, the bromide of ammonium, possesses remarkable power in rendering the mucous membrane of the fauces anæsthetic. I shall certainly continue its use, and make trial of it in some other conditions of disease of the genito-urinary apparatus.

How best to secure a smooth shin after fracture of the tibia.

In an ordinary way simple fractures of the bones of the leg are easily treated. As regards the length and straightness of the limb, there is, I think, scarcely ever any difficulty. You put the leg in junks, between side splints, or in a box, and take care that the great toe is in a line with the inner edge of the patella, and as regards the points mentioned you have no anxiety. There is, however, one source of annoyance in treating this form of fracture, and that often gives great trouble. In a certain proportion of cases, probably, at least, one in four, there is a tendency on the part of the lower end of the upper fragment to stick forward and inward. The displacement is usually not very great, and if it occurred in a bone which is well covered by muscles we should care nothing about it, but as unfortunate the tibia is here immediately subcutaneous, it is essential that we should get it level as well as straight. If it is not got level the patient will be annoyed to find when he gets up, and when the swelling has disappeared, that there is a sharp spine of bone in the lower part of his shin, just where he can

best appreciate such a condition, and where the bone ought to be perfectly smooth.

Some times the projection to which I allude even threatens perforation of the skin, and after union, in a few instances, it is sufficient to induce the surgeon to cut down and remove it. It often causes dissatisfaction to the patient, and I recollect a case in which it was made the basis for a charge of malpraxis. During the present year we have had two patients who had been treated for this fracture elsewhere, and who now made application to know whether anything could be done to remedy this deformity. It is therefore a genuine source of annoyance, and one of frequent occurrence.

In many of our surgical works you will find no notice whatever of this form of displacement, and one or two authorities even seem to consider that it is the lower fragment which is usually displaced forward. Malgaigne, however, is well aware of the real difficulty, and has invented an ingenious instrument, consisting of a belt and a sharp-pointed screw, with which to secure the bone backward.* As regards the occasional displacement of the lower fragment forward, I can assure you, from the careful examination of a great number of cases in reference to this point, that it is decidedly infrequent, not once in a dozen cases, and that almost always the line of fracture passes obliquely through the tibia from behind forward and downward, giving to the end of the upper fragment a sharp point, and allowing it to rise in front of the other. The fractures of which I speak are usually caused by indirect violence, and occur at the commencement of the lower third of the bone.

My chief object in these preliminary remarks is to recommend a very simple and effectual means of remedying this displacement. It is that of elevation of the limb. We always here use a sling apparatus for these fractures, and the elevation to which I refer consists in slinging the foot six inches or more higher than the knee; thus the whole leg slants upward. If you wish to test the efficacy of this plan, try the experiment in the first case you meet with in which the sharp end of the upper fragment projects, put your finger on this sharp end, and then let some one gradually lift the foot up into the air—I am of course supposing that the limb is fixed on a back splint. At a certain point of elevation you will find the projecting end sink into its proper place.

Formerly I used to be very much troubled with these cases, and used to adopt many expedients. The projection is not due to impaction, at least not in most cases, for if you put your thumb on the end, you can with moderate force press it backward, but it will rise again the moment you remit the pressure. We used to try by the pressure of a small splint placed in front directly over the bone, to effect the object, and I adapted a modification of Signorini's tourniquet to this special purpose. These methods, however, have the disadvantage of injuriously pressing the skin, and sometimes they cannot be used in the very cases which most need them. Then we tried

*See *A Treatise on Fractures*, Packard's translation, p. 642; see also Hamilton's work, p. 474.

elevating the lower fragment by putting pads under it. This often succeeds fairly but not perfectly. The plan of slinging the whole leg high was hit upon by a very industrious student of this Hospital, Mr. J. H. Gray. In a case to which he was the dresser, I had encountered much difficulty, and at length directed the leg to be again taken down and pads put under the lower fragment. At my next visit Mr. Gray informed me that he had gained the end perfectly by elevating the leg. I found that it was so, and immediately set about experimenting in other cases. Since then we have used Mr. Gray's plan in a great number of cases, and I have never been disappointed in it. I do not say that it will always supersede the employment of direct pressure, but it has always very much facilitated adjustment, and it has no drawback that I know of.

Death from an attempt to reduce an old standing dislocation of the humerus.

I am about to relate a warning case.

An elderly woman was admitted so tipsy that she could give no account of herself, with a dislocation of the right humerus into the axilla. The House surgeon and dressers tried their utmost to reduce it, and failed. In the morning, when sober, or nearly so, she informed us that her shoulder had been dislocated for several years. I discredited her statement, believing that, as is not unfrequently the case, she wished to deceive us, in order to prevent us putting her to pain. We accordingly gave her chloroform, and again tried to reduce. The method tried was by extension directly outward using the knee in the axilla as a fulcrum. We did not employ pulleys, nor resort to any unusual degree of violence. The extension was manual only. We did not occupy more than ten minutes in this second attempt; finding that the bone did not move, I concluded that the woman's story was correct, and desisted. Great inflammation followed this attempt. The shoulder joint suppurated. The abscesses were freely opened, but the woman, who had been a very intemperate person, in spite of liberal support, sank into a very low condition, and at length died. At the *autopsy* we found a new cup of bone, formed below the glenoid cavity, for the reception of the head of the humerus. The soft tissues of the joint were wholly destroyed by suppuration, and every trace of cartilage removed.

The chief interest of this case seems to me to rest, not in the circumstance that we discredited the statement of a drunken old woman, when unfortunately it was perfectly true, but in the illustration it affords of the dangers which some times attend attempts at the reduction of old dislocations. No injury had clearly been done by the first attempt, it was the second one which caused the mischief. Yet this attempt was by no means a prolonged or violent one. I have often tried much longer and used much more force.

As regards the degree of usefulness retained by a permanently dislocated shoulder we may just note that this woman assured us that she had experienced no appreciable detriment. She "could do anything with the arm; it was just as good as the other."

In another case, which was under my care a few months ago, an old woman

who had a dislocation into the axilla of three months' standing, said that her arm was quite useful to her, and that, "excepting lacing her stays with it, she could do anything." She could not get the arm well behind her. She was most unwilling that anything should be attempted. These facts, showing on one hand that this form of dislocation does not entail much inconvenience if left unreduced, and on the other that attempts at reduction in old standing cases are not devoid of danger, seem to me to point very clearly to our wisest line of practice.

Elevation of the limb not necessary in the treatment of transverse fractures of the patella.

I have for some time past wholly abstained, in the treatment of transverse fracture of the patella, from what I believe to be the utterly useless plan of elevating the limb. We let the limb lie straight on the bed, much to the patient's bodily comfort, and without the slightest detriment to his patella. My theoretical reasons for discussing the old plan are two; one physiological, and one anatomical. 1st. That muscles, when the limb is at rest, are not contracted but quite flaccid. Examine the patella of a person in bed, and you will find it loose and movable; the muscle is not acting on it in the least. Make the same examination in a case of fracture of the patella after the first spasm has subsided, and when the patient is not voluntarily contracting his quadriceps, and you will again find that muscle wholly relaxed. My second objection is, that even if the quadriceps were in constant action, which I assert it is not, you could not diminish the distance between its attachment and origins, in any material degree, by elevating the limb. All that part of the muscle which arises from the femur (the crureus and two vasti) will be not in the least altered. Lift the limb as high as you like, you move both insertion and origin together and equally, and can not possibly alter their relative position. The rectus itself arises it is true, above the hip joint, but it is so close to the latter that the length of the muscle can be but very little modified by flexion of the thigh. My chief reason is however obtained from clinical experience. Over and over again have we proved, by experiment in elevating and lowering the limb in cases of fractured patella, that position did not in the slightest prevent the bringing down of the upper fragment. All that we can profitably effect in the way of approximating the origin and insertion of the muscle in which the patella is a sesamoid bone, is done when we straighten the limb at the knee, and thus bring up the lower fragment. In the almost parallel accident of fracture of the olecranon, we adopt a similar practice, *i. e.*, make the elbow straight in order to bring the lower fragment near to the upper, but no one ever dreams of confining the arm backward and upward because one head of the triceps arises from the scapula.—*Lond. Hosp. Reports*, Vol. 2d.

OBSTETRICS, DISEASES OF WOMEN, MATERIA MEDICA, AND THERAPEUTICS.

By THEOPHILUS PARVIN, M. D., Professor of Materia Medica and Therapeutics, Medical College of Ohio, and Clinical Lecturer on Diseases of Women at St. John's Hospital.

ART. I.—*Annual of Therapeutics.** By THEOPHILUS PARVIN, M. D.

We propose presenting a few abstracts from this valuable little volume, just received:

Morphine as a Remedy for Stammering.—Here is a new and interesting application of morphine, reported by M. Sæmann.

The author was consulted by a lady, twenty-five years of age, who had suffered for three or four years with stammering of remarkable severity; against which, however, she had not employed any rational treatment. M. Sæmann thought that a sub-cutaneous injection of acetate of morphine would produce some amelioration; but by mistake he injected two *milligrammes* and a half of nitrate of strychnine. From this the result on the following day was, that the stammering was increased in a deplorable manner. To repair the error, an injection of a third of a grain of acetate of morphia was at once made. This was almost immediately followed by a profound sleep, which continued for eight hours. The following day the utterance was much more easy than before; and this amelioration was even more decided in the course of animated conversation. The injections were repeated, to the amount of a sixth of a grain, every two days, for a fortnight, and the amendment continued to progress.

Antagonism between Opium and Belladonna.—Whether such antagonism exists, seems to be still a mooted point. Two cases of opium-poisoning, successfully treated by belladonna, by Blondin, are quoted, preceded by some judicious remarks by the editor Bouchardat, of which the following, we believe, especially valuable: The principal thing, in

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* Annuaire de Therapeutique, de Matiere Medicale de Pharmacie et de Toxicologie, Pour. 1866. Par A. Bouchardat, Paris 1866.

the treatment of poisoning with opium, is to keep the patient awake in order that the morphine may be eliminated by the kidneys. When belladonna, faradization, flagellation conduce to this important end, nothing can be better.

Following the cases of Blondeau, is a notice of a thesis by M. Camus, with some extracts from it. The author, it appears, has traced the history of the alleged antagonism as far back as 1570, when Prosper Alpin and Lobel observed that opium combined with belladonna weakened its action. In the course of this retrospect, he quotes several cases where opium-poisoning was treated by belladonna, and among these is one in 1856, by Dr. Mussey of Cincinnati.

The conclusions which M. Camus draws from his investigations and experiments, are these: "The supposed antagonism between opium and belladonna, appears to us the result of facts wrongly interpreted. This antagonism is found neither in the rabbit nor in the sparrow; we think it does not exist any more in man."

Otitis from Tobacco and from Alcohol—(TRIQUET).—This special otitis is manifestly connected with that morbid state of the constitution which is produced by the long-continued action of injurious substances, and in particular of tobacco and alcohol, especially in young men, and even in persons more advanced in age. A kind of benumbing or torpor in the ear, with a peculiar feeling of coldness in the same organ, but almost never of pain; an absence of cerumen in the auditory canal; a condition entirely normal of the *membrana tympani* and of the *ossicula;* little or no pathological vascularity of the membranes; then add extreme dryness, with very small granulations of the pharynx, of the nasal fossa of the tubes and of the middle ear: such are the principal symptoms which characterize this singular affection in a way quite peculiar. It is rare that one ear only is affected; more often the two ears are affected at the same time; only there is almost always one which was first diseased, and which is more deaf than the other. Without being very decided at the outset, the deafness becomes very inconvenient and increases rapidly. Noises exist almost always in the first period of the disease; these have a whistling tone. This sign is very important.

Hitherto, this otitis of drinkers, of snuffers and of smokers, has been confounded with what is called nervous deafness, because its cause was not recognized.

M. Sichel has called attention to a form of amaurosis equally determined by the use of alcoholic liquors and tobacco.

Curare in Tetanus—(JOUSSET DE BELLESME)—Should be used at

the commencement of the disease, and by sub-cutaneous injection; at the same time the wound may be bathed with a solution: its internal administration the author regards as useless.

Arsenite of Strychnia.—This new salt may be prescribed in doses of one or two centigrammes, in obstinate intermittents.

Camphor Cerate in Erysipelas—(BAZIN).—This treatment consists in the application to the parts affected with erysipelas, of an ointment thus composed: Cerate, 20 grammes; Camphor, 1 to 2 grammes. A thin layer of this should be placed upon the surface, and then a sheet of batting over it.

Malgaigne employed, for a long time, camphorized applications in the treatment of erysipelas.

Pills of Apiol.—These are best made with almond soap.

Preparation of Copaiba, Odorless and Tasteless.—Dr. Beyran recommends the following formula, in which the tar not only destroys the very disagreeable odor and taste of copaiba, but also increases the efficiency of this remedy in the affections of the urethra, for which it is generally administered: Copaiba, and tar, of each 30 grammes; Magnesia, q. s. Mix, and make into a mass.

Tar to prevent the reproduction of Furuncles—(HARDY).—The remedy should be given each day in the form of tar-water; it is the best remedy* that can be prescribed. Bouchardat states that he has succeeded in some cases in preventing the return of boils, by administering sulphur and aloes in combination.

Phosphorus and Phosphoric Medication.—(TAVIGNOT).—"I prescribe phosphorus in liniment and in pills; and employ them simultaneously for the attainment of the same end, since dissolved phosphorus is absorbed by the skin as well as it is by the stomach, without altering the texture of the tissues with which it is brought in contact; one can then continue its employment under these two forms as long a time as the disease appears to require it. This is the formula for the liniment of phosphorus: Oil of sweet almonds, 100 gr.; naphtha, 25 gr.; phos-

* How rejoiced Bishop Berkley (whose *Sirius* many a doctor might spend the necessary time worse than in reading), would be, at this new and important application of his favorite remedy! The metaphysicians may tell us that *what the Bishop believed made no matter*, and physicians will understand this in a new sense, if tar-water, indeed, proves as effectual in the practice of others, as it has in that of M. Hardy, in preventing the troublesome abscesses known as furuncles. We imagine if the bishop were alive, his only regret in view of this new use of tar-water, would be that Job was not a co-temporary, so that its use might be tried in his case.

phorus, 0.25 gr.; dissolve in a water-bath at a temperature of from 45 to 50 degrees.

The mode of preparing the pills is the following: Oil of sweet almonds, 8 gr.; phosphorus, 0.10 gr.; dissolve at 45 to 50 degrees in a water-bath. Add cocoa butter, 8 gr. 40; powdered marshmallow, 18 gr. The mass is to be divided into 100 pills, and these are to be coated with gelatin or with sugar.

"By adding to the pill mass five grammes of the precipitated carbonate of iron, we have phospho-ferruginous pills which will fill a double indication at the same time, acting upon the nervous system and upon the blood more or less impoverished."

The dose of the pills of phosphorus is, for children from three to seven years of age, one to two a day; for adults, four to six.

Tavignot gives the following as the three most important phenomena resulting from the administration of phosphorus:

1. Given at the period of childhood, it appears to me to hasten the organic evolution which terminates in puberty.

2. Oftenest, it quickens the digestive functions, and increases the appetite.

3. Its action upon the genital system is plain and constant; this is only a question of age on the one hand, and of dose on the other. Phosphorus acts much more decidedly upon the reproductive organs of the old than upon those of the young,—"momentarily exciting functions unexercised for a long time, with great energy, while it adds scarcely anything to the activity of those exercised normally." * * *

The conclusion of this article is the following: "We say, then, that alone it constitutes the best of all treatments in very many of the nervous affections of the eyes, such as amaurotic amblyopia, chronic glaucoma, muscular paralysis, etc.; while, when associated with iron, it has a reconstituent action, most manifest in the different anæmic and chlorotic conditions, simple or complicated with hysteria."

Sulphites of Soda and of Magnesia: external employment.—M. Gritti uses the sulphite of soda in the form of solution and of *glycerole*. The solution is made in the proportion of ten parts of the sulphite to one hundred of water. The *glycerole* contains eight parts of powdered starch, ten of the sulphite, and eighty of glycerine. The sulphite of magnesia should be used in the form of powder, and serves especially to cleanse and lightly cauterize indolent wounds, with thin discharges or having a tendency to gangrene.

The results from this plan of treatment are thus summed up:

1. It diminishes the secretion of pus in all kinds of wounds.

2. It destroys the odor of superficial, and diminishes that of deep wounds.

3. It renders viscous and dense the pus secreted from large abscesses, and that which exudes from the surface of wounds, so as to constitute a protective dressing.

4. It destroys the anatomical elements of pus, that is, the cells, leaving of them only the *molecular detritus*.

5. It stimulates and makes uniform the work of repair.

6. It lessens the sensibility of the wound.

7. It hastens cicatrization.

8. It is well-tolerated by the wound and by neighboring parts.

Glycerine in Skin Diseases—(GATINE).—Glycerine, either pure or medicated, is an excellent remedy, probably the best, in lichen, *lichen agrius* especially, prurigo, hyperæsthesias, pityriasis; its efficacy is more questionable in lupus, carbuncle, chilblains. It gives uncertain results, oftenest bad, in eczema at every period, in pemphigus, impetigo, ecthyma, and finally in psoriasis.

Treatment of Urticaria—(HARDY).—M. Hardy prescribes alkaline baths, if the urticaria is not very severe, then some baths of sublimate. He considers the last as the specific for the itching.

A topical application which is equally excellent to relieve the itching and which sometimes produces an immediate sedation, is the following powder: White oxide of zinc, 10 grammes; camphor, 5 do.; starch, 40 do.

M. Hardy prescribes also in similar cases, lotions made with one quart of vinegar and three of water; this solution is applied with a sponge. Instead of the vinegar and water, we may use nitric acid and water,—one or two grammes of acid to nine litres of water. The internal medication consists of orangeade, lemonade, barley-water, etc. Then comes the alimentary regimen which is very important. M. Hardy rigorously excludes all pork, fresh as well as salted; he prohibits all shell-fish, and certain vegetables such as cabbage, which, like strawberries, may occasion urticaria and strophulus.

Ether as a Remedy for Tape-Worm—(LORTET).—The abundant inhalation of ether, its direct absorption by the intestinal canal, when given in capsules or incorporated with syrup, determines anæsthesia of the entozoa, which are carried without effort as far as the rectum, whence a gentle purgative expels them entire and living. Although my experience as yet embraces but a small number of cases, five in man, that which has always succeeded, even in two patients in whom everything else had failed, is taking, at a single dose, sixty grammes of

ether followed after two hours with thirty grammes of castor-oil. Each time the tænia was removed without the patient's suffering; the parasite was entire or almost entire, and its cephalic extremity intact.*

Employment of Ox-Gall—(WOLF).—Ox-gall is employed as a tonic in dyspeptic affections when these are dependent upon an atonic condition of the stomach and intestines. Its utility in those cases where it is necessary to produce an active excitement of the intestinal tube, and in those where, from deficient biliary secretion, an obstinate constipation has ensued, establishes its title as a purgative. In these cases, the ox-gall has rendered the author more service than all other therapeutical agents indicated. It is by this, also, that he has cured a patient

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* We read this translation to a medical friend, when immediately his impetuous Muse compelled him to the utterance of the following lines, not on "Ethereal Copulation," but on *Ethereal Vermifugation.*

Let De Quincey talk of *laudanum,*
To soothe the weary brain,
And Simpson sing of *chloroform*
In torturing labor-pain:

To Lortet's balmy *ether*
The Tænia hath sung,
For the horrid day of cruelty
To the wormy race is done.

"No more by *turpentine* and *oil*
We're wickedly torn loose;
By *santonine* compelled to uncoil
From out the gastric juice;

"Or *pumpkin seed* decoction;
Or nasty *oil of fern*
To sicken, then purge us
Into the burial urn.

"No more the painful *cowhage*
With thousand poison-points,
Will lacerate our pro-colex,
Or tear our swelling joints.

"For now the balmy ether
Is vermifuge most kind;
It causes blissful slumbers,
And we dream of other swine."

No more big tape-worms grumble,
Or little tænia weep:
Without being torn asunder
They sweetly fall asleep.

presenting all the symptons of *cirrhosed liver; the icterode skin, habitual constipation, and the progressive emaciation. When it is necessary to produce evacuations from the bowels, the author dissolves from four to six drachms of the extract of ox-gall in six ounces of aromatic water, and administers of this solution a table-spoonful four times a day. When employed as a tonic, it must be given in a much smaller dose.

With reluctance we now, for the present at least, take leave of this little volume: we may hereafter present some other translations from it.

Art. II.—*Precocious Menstruation.*

Exceptio probat regulam—one of the stumbling blocks of logic—finds an illustration in those cases where menstruation is established in the period of life which physiologists know as that of Infancy, cases which are numerous enough to leave no doubt of their occurrence, and rare enough to make every new one of professional interest.

We had the good fortune a few days since, through the kindness of our friend Dr. Day, of Shelbyville, Ind., to see a girl of four years and a half, who menstruates regularly, and has for a year. But before detailing this case we propose briefly to mention some other cases heretofore recorded.

In *Meckel's Archives*, 1827, an example of early menstruation is given. At birth the child was of an ordinary size; but after the first month she commenced to grow rapidly, and at nine months was of the usual size of a child of a year and a half old. About this time she passed from the vagina a few drops of blood; at eleven months of age she had another and more abundant sanguineous discharge; and at the same time the mammary gland began to be developed, and hair appeared on the mons veneris. At fourteen months a third, and at eighteen months, a fourth sanguineous evacuation from the vagina. The whole physical development of the child was

* We are reminded of a case of our own, under treatment last summer,—a case presenting the symptoms of cirrhosis,—the physical enfeeblement, the jaundice, the anæmia, the continued emaciation, but not the constipation; on the contrary, instead of this last condition, there were attacks of diarrhœa, with pain and flatulent distension of the stomach and intestines, results, as we believe, of the failure of digestion. (Possibly practitioners may some times be misled by the statement usually made in our systematic treatises on *Practice*, that in *cirrhosis* the bowels are *constipated*. The statement of Frerichs (Clinical Treatise on Diseases of the Liver, vol. II, p. 47), is, "the bowels are in most cases costive, particularly in the early stages of the disease; at a later period, diarrhœa is more frequent." He subsequently states that he has "met with persistent diarrhœa, ten times in thirty-six cases"). The urine was loaded with lithates, and had a specific gravity varying from 1025 to 1030. Examining this fluid by Dr. Harley's test, it was easily ascertained that the jaundice was the result of *non-elimination*, and not of *re-absorption*. This patient was given ox-gall and strychnia; subsequently, nitro-muriatic acid and quinia. The result was most happy; for several months he was in excellent health.

precocious; but her mental faculties were not greater than those of other children at her age.

Dr. D. Rowlett, of Kentucky (*Transylvania Journal of Medicine*, Oct. 1834), records the case of Sally Deweese, born April 1823; menstruated regularly from the time she was twelve months old, until 1833, when she became pregnant, and in April 1834, was delivered of a healthy female child, weighing seven pounds and three quarters.

The third case is that recorded by Dr. Carus, of Dresden, 1842, in these words: Christiana Theresa, a natural child, was born in the mountains of Saxony; neither her father nor mother was of a robust constitution. She was scarcely a year old when she began to grow rapidly. At the end of her second twelve months the catamenia appeared, and have continued ever since to flow regularly once a month. The Academy of Medicine of Dresden, sent for both her and her mother, and in order to examine more particularly into the case, kept them under their observation during several weeks. The infant was thirty-seven inches three lines long. The mammæ were firm, like those of a girl of sixteen. Her body was stoutly made, and the genital organs were covered with dark brown hair. The physiognomy, and tone of voice were childish, which contrasted singularly with the strength of her body. Her intellectual functions were equal to those of a child three years old, and her head was covered with beautiful dark brown hair.

Mr. Whitman (*Northern Journal of Medicine*, 1845), relates the case of a child, who from a few days after birth, had her catamenia regularly at periods of three weeks and two or three days, until her death at the age of four years and some months. At this last period the development of her body was very striking, equaling that of a girl ten or eleven years of age. The mammæ were unusually large; the mons veneris collapsed, but well covered with hair—the labia pudendi sparingly so, though these organs themselves were of an unusual size for a child. The development of the pelvis and of all the deep seated genital organs was very considerable; and the lower limbs were proportionately large.

In the *London Medical Gazette*, Nov. 1848, there is recorded the case of a girl who commenced to menstruate at the age of ten years and six weeks, and had a regular return of the catamenia in somewhat profuse quantity until conception, and at the age of twelve and a half years, she gave birth to a living and for the most part, healthy infant.

In an abstract of Dr. Szukit's investigations in reference to *Menstruation in Austria* (*Hays' Journal*, Oct. 1858), the following is found: Although in Austria, menstruation most commonly occurs between the fifteenth and seventeenth years, many cases have been recorded of its much earlier occurrence. Wilson observed a case in which it occurred in the fifth year; the breasts being as large as those of a marriageable female. Scanzoni records one case at eight years; D'Outrepont, one at nine months; she had protuberant breasts, and menstruated every four weeks till her death in her twelfth year. Boisment records two cases—in one, menstruation commenced in the third month; in the other, in the third year. Similar observations are

recorded by Madame Boivin, Dieffenbach, and Martin Wall. In France early menstruation is more common than in Austria, as Boismont, in 1,200 cases found fourteen who menstruated before their tenth year.

In Cazeaux's Midwifery (*Third American edition*, p. 84), we find mentioned on the authority of Dr. Susewind, the case of a child seventeen months old, who menstruated regularly, and had, since she was twelve months old; her breasts and mons veneris, were those of a girl of fourteen or fifteen years of age; and on that of Lenhossek, another case in which menstruation commenced at nine months, and at two years the subject presented all the external signs of puberty.

We will now present a few particulars in reference to the case which we have recently seen. The mother of this child is under medium size, very delicate; menstruated first at twenty years of age; married at twenty-four, and two years after marriage, gave birth to this her only child. As mentioned previously, this child commenced to menstruate at three years and six months of age. The general appearance of the child is that of a stout healthy girl of ten or twelve years; her weight is seventy-five pounds; her height three feet eleven inches; her voice is rather coarse and harsh, at any rate it has not the softness and gentleness of infancy; her physiognomy is that of early childhood; she is timid and "babyish,"—mentally and morally, she presents none other than the characters which might be expected in one of her age. But her most marked physical characteristics, as will be conceived, are those of a sexual sort. The mons veneris, though destitute of hair, and the labia are well developed, and the mammary glands are quite large and well formed; indeed in size they might answer very well for one sixteen or eighteen years of age. The circumference of the chest, measuring over the mammary glands, is twenty-seven inches; a line encircling the lower part of the trunk and fixed at either side at the middle of the crest of the ilium, measures thirty-one inches. The menstruation recurs regularly, and continues three days; she does not seem to have any special suffering at these times; the amount of catamenial discharge is about equal to the average observed in the adult during the same length of time. T. P.

ART. III.—*On the Superiority of Chloroform as an Anæsthetic Agent.* By W. C. Sédillot. Translated from *The Gazette des Hopitaux.*

[The relative merits of Chloroform and Ether have been canvassed recently in some of the French Medical Journals. We give one of the articles which is worthy of attention from the high authority from which it proceeds.—J. C. R.]

M. Petrequin, the character of whose works is so justly appreciated, sent a communication to the Academy of Sciences, on the 4th of December, 1865, entitled "Etherization and the Surgery of Lyons, a contribution to the history of surgical anæsthesia in France."

It is a plea in favor of ether and against chloroform, and M. Velpeau has responded to it with all the authority of his vast experience. We should have added nothing to his judgment, had it appeared to us to have been accepted; but "Lyonnese surgery," as M. Petrequin, terms it, does not

alone believe itself in possession of the truth—it imagines that it discovered it, and considers it a point of honor to spread it abroad and ensure its triumph.

These pretensions are not well founded, and the subject of anæsthesia is of so great interest, both to humanity and to science, that I trust the Academy will receive another communication upon the subject.

No one has called in question the admirable advantages of ethereal anæsthesia, for the discovery of which, we are indebted to the American, C. Jackson. All surgeons have praised, extolled and practiced it. What then are the especial points claimed by the Lyons school. They use at Lyons pure rectified ether of 62 or 63 degrees. But M. Elie de Beaumont immediately remarked that Jackson was the first to recommend the employment of perfectly pure and concentrated ether.

[Here follows a paragraph upon the quality of the ether usually employed in France, which is not essential to the remainder of the article.—Tr.]

These details prove in the most positive manner that we have constantly employed in our clinics, ether, at least as pure as that of Lyons. Besides, M. Petrequin might have read in my memoir upon "The insensibility produced by chloroform and by ether" (1848), a series of experiments in which I added alcohol to ether in varying proportions, in order to demonstrate that the period of excitement was produced by the former agent. We have experimented with, and abandoned the use of the bag of Roux, of Toulon, in which the patients head is inclosed, and we have studied with the very greatest care the different modes of etherization.

We were, then, perfectly acquainted with the conditions and the advantages of the employment of ether, when M. Simpson, on the 10th of November, 1847, communicated to the Medico-Chirurgical Society of Edinburg, his paper upon chloroform, discovered by Souberain in 1831, and so well studied since by the illustrious Secretary of the Academy, M. Flourens. On the 15th of November, 1847, we administered this new anæsthetic to man, after numerous trials upon animals.

If we have given our preference to chloroform, with Simpson, Roux, Velpeau, and the majority of surgeons of Europe and America, it has not been in ignorance of its dangers. If it is true, we said in 1848, that accidents have been occasioned by ether, we can not conceal that the use of chloroform, in unskillful hands, will make the risks very much greater.

At the Academy of Sciences, 1847, as well as at the Academy of Medicine, 1848, and the Surgical Society, 1851, we proclaimed the grave responsibility attending the inhalation of chloroform, and in one of our publications, 1852, we sustained the three following propositions:

I. The administration of chloroform is an art which requires attention during every moment, much skill and experience.

II. Every time chloroform is administered the question of life or death is thrown into the scale.

III. Chloroform, pure and well employed, never kills.

M. Velpeau declared before the Academy that he had administered

chloroform to several thousands of patients without having had the misfortune to lose one. The same success has attended our clinics, civil and military, although we have resorted to the remedy with the greatest boldness, under all circumstances and at all ages, without admitting the possibility of idiosyncrasies incompatible with this agent.

To pretend that chloroform, pure and well employed, can occasion death and strike the patient down as by lightning, in spite of all precautions, it would be necessary to show that this terrible accident had happened to the warmest partisans of chloroform; and when experience shows that their practice is exempt from fatal cases, while they occur most frequently with practitioners of little experience with the remedy, we are forced to see in this result something more than simple chance.

We will not limit ourselves to laying down arbitrary formulæ. In indicating the danger we will give at the same time the means of avoiding it.

Watch, first of all, the freedom of respiration, and let the inhalation be intermittent, in order to avoid those progressive effects which are really perilous.

Chloroform possesses the remarkable property of continuing its action upon the economy after the cessation of its employment.* We have shown, in 1848, that animals may die from chloroform when the respiration and the circulation were not suspended and seemed not compromised, and that they succumbed, although left in the open air, and the inhalation of chloroform was suspended. The indication is evident; interrupt the inspiration of the anæsthetic before muscular resolution is produced, and watch its effects.

These simple precautions, well comprehended and well applied, assure the harmlessness of chloroform, and our colleagues of the army have employed it with the greatest success in the most unfavorable conditions. M. Lustreman, principal surgeon and professor at Val-de-Grace, has sent me a most instructive note upon this subject. "During the campaign in the East," says this skillful surgeon, "I chloroformed the wounded exhausted by scorbutus, diarrhœa, traumatic fever, abundant and prolonged suppuration, and by hospital gangrene. These poor moribunds, sent from the Crimea to Constantinople, had their last chance of salvation in a delayed amputation. All demanded to be put to sleep, and I had only to felicitate myself upon having acceded to their demands. Not one of them experienced the slightest accident attributable to the chloroform. I will add that they were anæsthetized in their beds, transported to the operating room, the amputation performed, and the dressings applied with that deliberation required by a peculiar disposition to hemorrhage, and returned to their beds without the

*[Would it not be more correct to state this as does, we believe, Snow: The air in the lungs, the "residual air" of respiration, being constantly loaded with the anæsthetic vapor, at whatever point of the process the sponge is removed from the mouth and nose, the absorption of that vapor already in the lungs must continue, and the narcotism therefore progress for a time, althought the administration of the chloroform be discontinued. It is a very important point in practice.—Tr.]

influence of chloroform being suspended for an instant. Thus, even in cases where life seems on the point of departing, complete anæsthesia can be considerably prolonged without danger." (See my *Medicine operatoire*, 3rd edition, vol. I, p. 19, 1865.

There can not remain any doubt upon the possibility of avoiding the dangers of chloroform. If it is asked why we continue to employ it in preference to ether, we answer with M. Velpeau: "Chloroform acts more rapidly, more surely, and gives a more complete calm and a deeper sleep."

The rapidity and the persistence of chloroformic anæsthesia, give it the superiority. The awakening from chloroform is slow and silent—that of ether rapid, loquacious and noisy. With chloroform we can practice upon the eyes, face and interior of the mouth, many operations impossible with ether, the transient effects of which are very slowly obtained. Chloroformic anæsthesia, prompt, facile and persistent, adds then to the resources of surgery without diminishing its safety.

Case of Double Monstrosity.—In the absence of Mr. Owen, Mr. Wills visited the patient, a spare, thin woman, æt. 21, in labor with her first child. He found one foot protruding, and immediately another, of unequal size. On comparing them it was found that they were two left feet. On further examination the foot of a right leg was found corresponding to the first, and another foot much higher up. On making extension of the *pair* for the purpose of delivery, the second left foot receded, the breech descended to the outlet, but could be brought no further. Mr. Wills imagined that he had to do with a monster, but of what kind could not distinctly determine. At half past one, three hours and a half after Mr. Wills' first visit, Mr. Owen came to his assistance, and, as the child first in advance was dead, it was determined to deliver; Mr. Wills still holding the opinion that the two feet, now to be felt only at the mouth of the uterus, belonged to the same child, and that the junction was at the shoulders, or that there was one large head—a specimen of which kind may be seen in the College of Surgeons' Museum. The delivery was accomplished in the following manner, under chloroform. Mr. Owen extracting by bringing down the presenting legs, and drawing backward; Mr. Wills introducing the left hand, finding the mouth, introducing a blunt hook with the right and thus bringing down the chin, and shortly after the head, when an abdominal attachment became manifest. The other or rather lesser child was easily made to follow by laying hold of the other feet. The woman was remarkably well the next day, and continued to make a complete recovery.

The Dissection.—The children were well formed, with the exception of their junction, one a little longer than the other, both males. Their union was by bone, cartilage and skin, placed directly face to face; the sternal extremities (ensiform cartilages wanting) were firmly attached by the bones and cartilages of four or five ribs on each side, for about seven inches in all; the skin and integuments of the belly expanded to form one abdominal cavity down to the umbilicus; the cord, double and in one sheath, entered the abdomen underneath and between the two children; the liver (one large mass) lay between the two, on the right side of the larger one and the left of the other, with one gall-bladder, from which issued two common ducts. There was one large spleen; the intestines were perfect and distinct in their course for each child; all the other viscera, thoracic and abdominal, were in duplicate and perfect.—*Trans. Obstetrical Society, of London*, vol. 7, 1866.

PRACTICAL MEDICINE, PHYSIOLOGY AND CHEMISTRY.

ART. I.—*Extract from a Lecture on Delirium Tremens.* By GEORGE JOHNSON, M. D., F.R.C.P., Professor of Medicine in King's College, Physician to King's College Hospital.

THE *treatment* of delirium tremens has passed through various phases, and undergone various modifications, in accordance with the theories which have at different times prevailed with respect to the nature of the malady. Until within the last fifty years, it was generally looked upon as an inflammatory disease. Many of the cases which the older writers called "phrenitis" were, in fact, cases of delirium tremens. The treatment then was by bleeding and other antiphlogistic remedies, and the result was most unfavorable. In the year 1813, Dr. Thomas Sutton, of Greenwich, published a tract in which he distinguished these cases of delirium, so commonly occurring in persons of intemperate habits, from cases of inflammation of the brain and its membranes. He first applied the term "delirium tremens" to the former class of cases, and remarked upon it that the name, though not perhaps the most appropriate, would serve to convey a notion of an essential symptom of the disease, and was sufficiently explicit for his purpose. He states that from the year 1798 to 1807 he resided on the eastern coast of Kent, first as physician to the forces, and afterward as a private practitioner. He there found that delirium tremens was treated in two very distinct ways by different practitioners; the one party employing antiphlogistic remedies, the other using narcotics: and, as he says, he "soon perceived that the latter practice carried with it all the success" (p. 5). He adopted the successful mode of practice, and, after giving it a fair trial, published a very sensible treatise on the disease. He states that in the course of three years he had treated twenty-two cases of delirium tremens, and that only four of these had died. He estimates the mortality under the antiphlogistic treatment as two out of three.

Since that time the treatment of delirium tremens by narcotics, and especially by opium, has been gradually established as the orthodox practice; and it is, on the whole, a highly successful practice. But it does not always succeed. The doctrine that opium is to be given in large doses, and repeated fearlessly until the patient sleeps, is a dangerous doctrine, and must often have led to a fatal result. There are

many patients who will die from the depressing effect of opium on the heart without being made sleepy by the drug. I had this fact deeply impressed upon my mind more than twenty years ago, when I was house physician to the hospital. A man who had taken repeated large doses of opium sank rapidly exhausted without a symptom of narcotism, conciousness remaining until within a few minutes of his death.

Recently another theory of delirium tremens has been advocated by Dr. Laycock.* This theory is that the presence of alcohol in the blood is the immediate cause of the disease, and therefore that the main object of treatment should be to eliminate the alcohol. Opium and alcohol must, according to his theory, be injurious in the treatment, since opium checks elimination, and the administration of alcohol tends to perpetuate the disease; yet, with curious inconsistency, Dr. Laycock states that a glass of wine with gruel at bed time is a very useful soporific in the treatment of delirium tremens.

The three chief modes of treatment, therefore, which have been pursued in this disease are—

1st. The antiphlogistic, now by general consent abandoned.

2nd. The treatment by opium, which is in very general use, and often highly successful; but which is attended with peculiar risks, the nature of which I will presently endeavor to point out to you.

3rd. Dr. Laycock's eliminative treatment, with abstinence from alcohol and opium.

I will now tell you what, in my opinion, are the main points to be attended to in the treatment of delirium tremens, and what are the peculiar dangers which have to be guarded against.

And first, bearing in mind the tendency to suicide, the patient must be constantly and carefully watched by a judicious attendant who has the power to exercise some moral control over him. The doors and windows should be secured, and razors, knives, and other means of mischief, put out of sight and reach. He should be kept quiet and undisturbed by noise or excess of light. It is better, if possible, to avoid direct physical restraint. If the patient be violent and difficult to control, secure the services of two attendants rather than have recourse to a strait waistcoat. I have known more than one instance of sudden death from exhaustion induced by violent struggling against the restraint of the waistcoat, and I have also known more than one instance of fatal exhaustion from struggling with injudicious attendants. Not long since a medical friend called one morning and desired me to go with him immediately to see a publican whom he had just

*Edinburgh Medical Journal, 1858-9, p. 289.

before seen with an attack of delirium tremens. On entering the room we found the patient gasping for breath and evidently dying; and we learnt that immediately after my friend had left his patient, less than half an hour before, he got out of bed and wished to leave the room. Three strong men who were present resisted his attempt to go out; a struggle ensued, and in the midst of it he suddenly fell exhausted as we saw him, and he quickly ceased to breathe. You see, then, how great is the risk resulting from violent exertion on the part of these patients, and how important it is to avoid any restraint which is likely to provoke a struggle. In some instances a patient who can not otherwise be kept in bed will remain perfectly quiet under the restraint of the waistcoat; but while he is thus restrained he must on no account be left alone. He may begin to struggle at any moment, and this struggle may cause rapid and fatal exhaustion.

To sum up, then, what I have said on the subject of restraint, the guiding principle is to prevent any violent exertion on the part of the patient—any struggle either with the strait waistcoat or with the attendants. A padded room, when it can be had, is the safest and most effectual means of restraint for a violent patient.

Having insured the safe custody of the patient, we have next to consider the method of treatment. Now, in the first place, bear in mind that delirium tremens is one of those diseases from which recovery may take place without any assistance from drugs. Medicines are of great use in the treatment; but they are not essential. It is, however, of essential importance that the delirious patient should be *fed*. The history of the disease teaches us that the immediate cause of the delirium is the exhaustion consequent on a defect of wholesome nutriment; and, until this defect be supplied, all attempts to procure the wished for sleep, which is so generally followed by a cessation of the excitement, are often useless and worse than useless.

Whatever else you do or leave undone, never neglect to feed a delirious patient. If he will take food when he first comes under treatment give it immediately, and let it be repeated as soon as he will take it. If there be, as there often is, a disinclination for food, with nausea and a coated tongue, an emetic of ipecacuanha, followed by a dose of calomel and colocynth, or a saline laxative, will be of use as a preparation for food and for the opiate, which may best be given at bed time. You may then give from a half to one drachm of tincture of opium, which I believe to be a better soporific in these cases than the salts of morphia; and a smaller dose may be given in three or four hours if necessary. The first object is to procure sleep. But here I

wish to impress upon you the necessity of great care and watchfulness. Do not make rash attempts to force on sleep by repeated large doses of opium. These attempts will often fail to procure sleep, and they may kill the patient. It is an undoubted fact, that opium in many of these cases has no soporific effect whatsoever. And not only in cases of delirium tremens is opium uncertain in its operation. When we give opium in ordinary cases of disease as an anodyne or a soporific, we can never be sure that it will cause sleep. In a considerable proportion of cases opium *prevents* sleep, and makes the patient more wakeful than he would have been without it. Another not uncommon effect of an opiate is to cause nausea and faintness. These two effects of opium should always be borne in mind in the treatment of delirium tremens. Remember that when opium fails to act as a soporific in delirium tremens it is not inert, and must not be given in repeated large doses as if it were; while it fails to procure sleep, it may be exerting a powerfully depressing and paralyzing influence upon the heart. The symptoms of opium thus acting on the heart are these: The patient continues wakeful, excited, and delirious, but grows rapidly weaker; the pulse becomes quick, small, and feeble; the pupils are contracted; the skin is bathed in a profuse sweat; and, if the opium be continued in large and frequent doses, the patient rapidly sinks, but remains wakeful and conscious until perhaps within a few minutes of the end. The opium in these cases acts as a powerful sedative on the heart, and in proportion as it does this it fails to exercise any soporific influence. If you find that opium is acting thus injuriously, you must immediately discontinue it, and give liberal doses of brandy, or the stimulant to which the patient has been accustomed. Full doses of quinine, too, will be of use as a tonic; and nutriment, either in the liquid or solid form, should be freely given.

It is an undoubted fact that the soporific effect of opium is often much more certain and decided when the medicine is given with some alcoholic stimulant than when it is given alone; and I have seen not a few cases of delirium tremens in which, after repeated large doses of opium have failed to procure sleep, a liberal allowance of the patient's accustomed stimulant, more especially when combined with food, has been followed by a long sleep, and this by an entire freedom from delusions and delirium. I scarcely need impress upon you that these unquestionable facts are quite irreconcilable with the hypothesis that the proximate and essential cause of delirium tremens is the presence of alcohol in the blood. If the patient refuse to take the opiate or other medicine which you are anxious to give, he may some times be

induced to take it mixed with his beer or other beverage. Both food and stimulants may be given by the rectum in case of need; and morphia may be introduced subdermically; but this mode of giving morphia requires at least as much caution as the administration of opiates by the mouth.

Chlofroform vapor has the immediate effect of quieting the delirium and excitement; but the quiescence is only temporary, and I have seen no permanent good result from it. The fat and flabby state of the heart in these cases is a bar to the incautious administration of chloroform.

When there is much flushing of the face and heat of the scalp, cold lotions or iced water in a bladder may be applied to the head with advantage.

You may have heard or read of large doses of tincture of digitalis having been given for the cure of delirium tremens. I consider this a very dangerous remedy. I have no doubt that some patients have recovered in spite of the treatment. When half ounce doses of the tincture have been given, it is to be hoped that the digitalis was of bad quality; the patient would then, at any rate, have the benefit to be derived from the stimulant action of the rectified spirit. I have heard of several instances of sudden death after the administration of large doses of digitalis, and it is only natural that these calamitous results should not, as a rule, obtain equal publicity with the cases of apparently successful treatment. A consideration of the natural history of delirium tremens suffices, I think, to show that the treatment by large doses of digitalis is irrational and dangerous.

To sum up, then, the main practical points which I have endeavored to impress upon you. Bear in mind that an attack of delirium tremens, as a rule, subsides in a few days without help from medicines of any kind. Let the patient be carefully watched and guarded and fed, and the excitement and delirium will gradually subside. In many instances opium is a valuable aid in the treatment, and it will often cut short the disease; but remember that it is powerful for evil as well as for good. Its use, therefore, requires much care and discrimination. Some form of alcoholic stimulant will often be of great use in calming the nervous excitement and procuring sleep. Lastly, when the patient has recovered from his attack, do not fail to impress upon him the moral lesson which his sufferings have been designed to convey. The tortures of delirium tremens are most assuredly intended to exercise a wholesome deterring influence on the self-indulgent and the intemperate, and in that light he should be taught to view them. The poet

Wordsworth has given the true interpretation to such spectral visions as which form so marked a feature of delirium tremens, in the following lines from his "Sonnets on the Punishment of Death":—

> "Ye brood of conscience—Spectres! that frequent
> The bad man's restless walk and haunt his bed,—
> Fiends in your aspect, yet beneficent
> In act, as hovering angels when they spread
> Their wings to guard the unconscious Innocent."

[*Lond. Lancet.*

ART. II.—*General Observations on Pleuritic Effusions.* By DR. FRASER.

Case 1.—G. P., a female, age 20, was admitted into the Hospital on 22d, of December 1858. About three weeks ago, having previously been in good health, she was awoke by an acute pain in the right side, followed by shivering and heat. She continued more or less ill, and on the 19th of December, having become worse, she came to the Hospital, and was immediately admitted as an acute case. When first seen, there was urgent dyspnœa, at times becoming orthopnœa, any attempt to lie on either side being followed by a feeling of suffocation, but the attempt to lie on the left side was unbearable, and produced, as she said, the sensation "of a lump passing right through."

On examining the chest, there was no enlargement of either side, but on the right side there was a slight bulging of the intercostal spaces, complete immobility of the parietes, marked dullness on percussion extending from the fourth rib downward; upon auscultation, no respiratory murmur, no bronchophony were heard, and no vocal fremitus was felt; while on the left side everything was normal save a degree of puerile respiration. An operation was at once determined upon, and fifteen ounces of clear limpid fluid withdrawn: marked instant relief followed to the pain and dyspnœa, and she could lie down with tolerable ease. Ordered two grains of calomel, three of Dover's powder, every second hour. A drachm of strong mercurial ointment to be rubbed into the affected side every night. To have milk diet, rice pudding, and three ounces of wine. Three hours after the operation the dyspnœa returned, and at 4 A. M., sixteen hours after the operation, it became very urgent. She expectorated large quantities of a puriform fluid.

December 23rd.—Cough, and dyspnœa still urgent, pulse 130, respiration 36; the ribs on the affected side expand moderately, and the vesicular murmur is to be slightly heard. To have a blister to the side. At midnight of the 23rd, gums tender, has had a slight rigor, but is now sweating copiously, dyspnœa less, to take the pills every three hours.

March 24th.—Has slept a little, cough less troublesome, countenance less anxious, less dyspnœa. Under the influence of mercury. Pulse 100, soft and full, respirations 30, respiratory murmur about the same as yesterday; space of dullness on percussion diminished; size of both sides equal. Stop

the mercury: have six ounces of wine; a blister to the side. From this time to the 25th February, when she was sent to Walton on the Thames, she continued to improve steadily. Occasionally a slight mercurial to keep the gums tender; but the treatment generally was wine, and good diet, tonics, anodynes, and once when there was a slight pleuritic pain, a few leeches were applied to the spot.

On leaving, the physical condition was as follows: Left side healthy throughout; right side, dull on percussion, anteriorly and posteriorly, from the fifth rib; and distant and obscure respiratory murmur to the extent of the dullness, both sides being equal in circumference. On the 25th of March she returned from the country; her general health very much improved; a very slight cough and dyspnœa; the dullness on percussion lessened, respiratory murmur nearly equally audible on both sides.

The case is given here unbroken, but during its running the different cycles were noted and commented upon. We shall now pursue the same course.

It is evident, gentlemen, from the dyspnœa and other symptoms, that we have to deal with an inflammation in the thoracic cavity; auscultation is not required to determine this point, and the physicians of old, from their astute powers of observing symptoms, would not have been at fault, and, from the "lancinating" pain,—called by French writers the "*point pleurétique*"—they would probably have localized the inflammation in the pleural membranes; but they could not, nor could we, be able, without the aid of auscultation and percussion, to assert whether it was pneumonia, pleuritis, carditis, or some other heart affection, or inflammation and spasm of the diaphragm. Let us observe the physiognomy of the disease first.

We see that the girl can not lie on either side. What becomes, therefore, of the force of the symptom so much relied on by many writers, that the patient *invariably* lies on the affected side in pleural effusion? They forgot to state that the value of this sign comes out in a later stage only of the disease, for, in the early stage as in the case before us, the semi-erect posture is the only one bearable. There is a reason why the necessity for the semi-erect position ceases when the pleura becomes filled with fluid.

Dyspnœa, as I have shown elsewhere,* is a most deceptive sign in all chest affections, in this especially, for it may be very intense when there is a very small effusion, and absent altogether when the pleural cavity is full. This fact is explained by this view of the cause of dyspnœa, "that it arises from the lung being hindered from any cause, in following up the expanding and uninjured chest wall," and "not from the absence of air from the air cells;" for if so, the dyspnœa would be most intense when the lung is most compressed, whereas it ceases when this condition arises; the lung having ceased to expand, the ribs cease to rise and fall, and, there being no attempt at approximation of the lung and parietes, dyspnœa ceases; but let ever so little of the expansive movement of the lung begin, by a portion more or less of the fluid being removed or absorbed, then, probably by a reflex action,

*On Wounds of the Chest, p. 45.

the intercostal and other muscles act on the parietes of the thorax, to bring the latter into contact with the re-expanding lung, and dyspnœa, which may have totally disappeared, again begins, and will continue more or less until the approximation is completed. The series you witnessed in this case. You will contrast the complete immobility of the right, with the free action of the left side. This would show, according to the foregoing statement, that the free movement of the lung has ceased, and the ribs no longer rise and fall, obedient to the inflating and emptying of the lungs; but whether from the pressure of fluid in the cavity or consolidation of the lung we are still uncertain.

There is no enlargement of either side of the chest, such as we are told to expect in cases of effusion; this also is a later symptom only, for in the early stage the pressure of the confined fluid has not endured sufficiently to cause a yielding in the bony case of the thorax. This sign is rendered doubly doubtful, as there may be a slight enlargemeut of the chest in the congestive stage of pneumonia; the same may be said of the bulging outward of the intercostal spaces; for time is required to effect this also. Some writers say that this bulging happens only when the fluid is pus, and that pure serum will not produce it. If this be true, it proves that time is requisite for the production of pus, and that the effusion is at the outset always serous—a subject to be by-and-by alluded to—and that the bulging out is a late symptom; when present, it is a most valuable sign. Dr. Stokes considers this bulging out as a consequence of a paralysis of the intercostal muscles; but I think that the mere pressure is sufficient explanation.

To arrive at our final diagnosis we have to remember that there are several diseases which may simulate pleural effusion. Tubercular consumption has been mistaken, and a tubercular cavity punctured; this can occur only under great carelessness, for the respiratory murmur is never so completely absent in phthisis as it is in empyema; and the dullness on percussion in phthisis almost always commences at the apex, whereas, in effusion invariably at the lower part of the thorax.

An abscess in the lung may easily be mistaken for an empyema; indeed, in extreme instances such as Case 8, p. 90, where the whole substance of the lung becomes broken down, I know no differential signs, for the condition is equivalent to an empyema. The history may help to a diagnosis.

Enlarged liver, with or without hepatic abscess, has been mistaken, and the resemblance may become still more perplexing if an hepatic or other abscess should burst through the diaphragm into the pleural cavity, and thus produce what may be called a false empyema. False empyema may be caused also by an abscess between the diaphragm and liver, but not implicating the structure of the liver; for this see Case 11, p. 93. Those cases related by German authors as to the (to them) mysterious disappearance of an empyema cotemporaneously with a discharge of purulent urine, must have arisen from an ulceration through the diaphragm, the pus oozing among the spinal muscles, and finally ulcerating into the kidney.

We have as yet made slow progress, for it is seen that the manner of

decubitus and the immobility of the ribs lead to no final opinion. We may easily satisfy ourselves that there is no heart disease, no affection of the diaphragm or liver, no tumor of any kind in the thoracic cavity or mediastina; and by this mode of exclusion we conclude that the affection in question must be either in the lung substance or in the pleura, in other words, a pneumonia or a pleuritis.

Thanks to the immortal Laennec, we can now establish a certain diagnosis by the aid of auscultation and percussion; and here let me impress upon you, while you have yet time and opportunity, the absolute necessity for attaining a knowledge of auscultation and percussion; for, without the aid to be obtained from these modes of information you will be thrown back into the darkness of former ages, but unpossessed of the exquisite skill of noting minute symptoms on which our forefathers depended, and we have only to read their writings to admire the correct opinions often arrived at by the means at their command, now too much neglected.

The importance of auscultation and percussion in this and similar cases can not be over-estimated, for it is not a question of minute and curious diagnosis only, but concerns the treatment, in which is involved the recovery or death of the patient. You will find a great assistance while acquiring a practical knowledge of auscultation and percussion in knowing the physical causes for the presence or absence, as it may be, of certain sounds; for instance, dullness on percussion, infers the presence of a solid body and the absence of air; clearness on percussion, *i. e.*, a tympanitic sound, must proceed from the opposite causes. Thus from knowing the physical condition of the parts you may predicate the sounds that will be heard; and upon hearing the sounds you may predicate with an absolute certainty the physical condition of the organs in question.

For facility of reference, I have placed in juxtaposition the different signs of empyema, as contrasted with consolidation of the lung; and if you will study this short Table, you have the key of the whole matter in your hand.

It is to be understood that these signs, strictly applied, refer to uncomplicated and advanced cases only, and do not include all the signs which may attend an acute attack.

EMPYEMA.	CONSOLIDATION.
1. Inability to lie on healthy side.	1. Inability to lie on diseased side.
2. Almost always bulging outward of the intercostal spaces.	2. Never bulging out of the intercostal spaces.
3. Parietes immovable.	3. Parietes immovable.
4. Always dull on percussion; except the patient be in the erect, semi-erect, or horizontal posture, then, *if the cavity be not crammed with fluid*, we may have a clear sound at the apex of the lung, the upper level of the thorax, and where there are pleural adhesions.	4. Always dull on percussion; although a tympanitic state of the stomach and transverse arch of the colon may reder the sounds more or less clear.
5. Great resistance to the finger on percussion.	5. Moderate resistance to the finger on percussion.

6. A total absence of the respiratory murmur, except close to the spine, at the apex of the lung, if the pleural cavity be not full, and at points corresponding to pleural adhesions.	6. A total absence of the respiratory murmur; except at the root of the lung, or a few points not already consolidated.
7. Metallic tinkling, unless the cavity be filled, or nearly filled, with fluid.	7. Never metallic tinkling, except in cases of abscess.
8. No bronchophony.	8. Always bronchophony, and especially at apex and root of lung.
9. No œgophony, unless the cavity be nearly filled with fluid.	9. No œgophony.
10. No vocal fremitus, except at the points of old pleural adhesions, and therefore seldom felt.	10, Vocal fremitus generally present, unless the entrance of air through the bronchial tubes is much obstructed, or the parietes very flaccid.
11. Affected side almost always enlarged.	11. Never enlarged, except in the early stage.
12. Often fluctuation.	12. Never fluctuation.

Let us see how we can apply the information derived from the foregoing table to elucidate the difficulty, if any, of the present case.

Let me warn you to expect to see cases daily in which all the signs and symptoms will not exactly "tally," so to speak, with those you will find laid down in books; if it were so, diagnosis would be a much easier matter than it is; but it is not so, and you must draw your conclusions from the aggregate. This variableness, although to a certain extent preclusive to medicine becoming an exact science, gives a charm to the true medical student, for it raises a constant claim upon his intellect and powers of observation.

The dullness on percussion shows that there is some condition of the inclosed lung which prevents the free and normal vibration of the particles of the thoracic wall; in other words, an absence of air which is the medium of the conveyance of sound. From the history of the case, we feel sure that the air is not displaced by a tumor of any kind, therefore it must either be a fluid compressing the lung, or solid fibrine effused into the air-cells, thereby displacing the air.

A very fine tactile perception is required in percussing the chest walls, to make out a difference in the resistance to the finger from fluid compared to solidified lung, therefore I do not place much dependence upon this for help.

Negative evidence may here be made very valuable. The absence of vocal fremitus for instance, which practically may be considered never felt in effusion, although by the Table it is stated to be felt under certain conditions; but this doubt renders it necessary for us to bring the next and last witness—auscultation.

Even this evidence is inconclusive, for the absence of the respiratory murmur may proceed alike from effusion or consolidation, however, the absence of bronchophony and vocal fremitus, the presence of the bulging of the intercostal spaces, and the early history of the case, lead us to a degree of certainty otherwise unattainable. I have raised all these doubts and diffi-

culties to show you that even with all the estsblished signs of auscultation and percussion they will not lead you to a true decision without careful consideration and reflection. In a case like the foregoing, it is not easy to assign accurately to each medicine given the actual amount of benefit derived; but I do think that, after the fluid was evacuated great good followed from the use of mercury and Dover's powders, and sustaining the strength by tonics and wine.

The foregoing case drew my attention to the subject of pleuritic effusions generally. The opinions I have formed upon reading the literature contained in the highly interesting papers and cases scattered throughout the periodicals of the day, conjoined with clinical remarks made at the bedside upon cases coming before me in this Hospital, are contained in the following paper. I have not gone into the whole question of pleuritic effusions and their general treatmeut, but I have restricted myself entirely to the question of operation. The first impression was that of surprise at the diversity of opinion prevailing in the works of many authorities, and although the majority advised thoracentesis in pleuritic effusions, still the number who were adverse to the operation was so large that no decided action could be taken from such contradictory evidence, and I knew from experience that when a case of pleural effusion occurs, there is always a degree of uncertainty as to what is best to be done, even when the diagnosis has been made certain; some recommending a faith in the action of medicines to excite into activity the faulty absorbents, such as mercury, iodide of potassium, emetics, opium inhalations, and others of all classes; some recommending an immediate operation: the views of the former being founded on the idea that the effusion is from an over action of the secernents and an inaction of the absorbents. Be this physiological question as it may, it is very obvious to practical men that a fluid having once escaped, which it does with unhappy facility, from the small capillaries, seems to have great difficulty in returning into the circulation.

The term Εμπύημα, from ἐν and πύον, was applied by the ancients alike to an effusion of pus into the pleural cavity, mediastina, liver, spleen, pancreas, kidney, etc., etc. At the present time it is limited by some to a collection *only* of pus, between the thoracic parietes and the lungs; by others, the term embraces an effusion of pus, serum, sero-albuminous, sero-puriform, or sero-sanguineous fluid, or pure blood into one or both pleural cavities. This general signification I shall adopt.

It is not to be wondered at that before the advantages of percussion and auscultation in diagnosis were attainable, doubts as to the propriety of thoracentesis should exist, from the uncertainty whether fluid was present or not and seeing that in those cases of "paracentesis *ex necessitate*" a successful issue rarely occurred. The cause of this unsuccess was overlooked, viz: that nature operated because art had refused to interfere in time. Curiously enough, this natural opening always occurs at the upper part of the chest, very often between the third and fourth ribs. This operation of nature can not have failed to attract attention from the earliest period, as on every

subject in medicine we can ascend to the school of the divine man of Cos, so also for a knowledge of this operation by art. There are two modes of operating described: by penetrating in the intercostal spaces, or trephining through a rib. In the former the opening was made either by a cutting instrument, or by means of the actual cautery. A minute history of the ancient operation is given by Trousseau in his *Clinique Medicale*, Vol. I, p. 628. From the earliest period to the time of Laennec this operation was more or less practiced, although every now and then an opposition was raise. Forty years ago the following words were written by Laennec: "Je suis persuadé que l'operation de l'empyeme deviendra beaucoup plus commune, et plus souvent utile, à mesure que l'usage de l'auscultation mediate se repandra."

Since that period many learned men have devoted their time in improving mediate auscultation; excessive refinement has been aspired to by some, others have been satisfied with a less degree of skill. But has the devout aspiration of the great man been answered? The reply must be in the negative. Whence proceed the causes of failure in Laennec's aspiration? Ist. A delayed diagnosis. There is no doubt that a practical knowledge of auscultation and percussion is not sufficiently prevalent, and long before the diagnosis in a given case of empyema is determined, the time for success in the operation is passed. 2nd. If the time be not passed, then, as before stated, doubts arise and a second cause of delay is created in the attempt to produce absorption by medicines. The first cause can be obviated only by a more extended and more correct knowledge of auscultation, which is to be obtained only in the wards of the Hospital. The second cause will cease when we reflect that we can place but little dependence on the action of internal remedies in removing serous or purulent effusions, although several writers hold that pleural effusions are frequently absorbed, and so they may if the patient be otherwise healthy and vigorous, by the aid of mercurials and other medicines which may induce absorption; but if the health of the patient be already broken down, then the action of mercury on the already debilitated body will be more injurious than the operation, as in Case 2, p. 82.

I believe that pericardial serous effusions are often absorbed, but not pleural (the cause of this difference I can not explain: Trousseau states that effused blood is readily absorbed); and thus the mercurials do not act so much, if at all, in causing absorption as in preventing a continuous effusion. I can not suppose that the dense unorganized membrane has any absorbing power, and if it has any, the pressure of the fluid will keep up a constant irritation antagonistic to absorption. Several cases illustrate the inutility of mercurials, unless previously aided by operation, in removing effusions. Case 2, p. 82, shows the baneful effects of mercury in causing a wasting diarrhœa.

The result of Cases 3, p. 83, and 5, p. 86, go to support the same view. On the other hand, Case 4, p. 85, may support the views of the mercurialists.

Practitioners are aware that little reliance can be placed on the action of medicines in removing pleural effusions; and if this be the admitted fact,

thoracentesis becomes the chief if not the only means left to enable us to effect this desirable object; and I am satisfied that if the operation will not always save, it will assuredly prolong life (as in Case 13, p. 96), and I am not aware of any case in which it has been the immediate cause of death.

An argument against the operation is the supposed injurious effect from the admission of air into the pleural cavity, thereby converting a serous into a suppurative effusion. Dupuytren, Hope, Thomson, held this opinion; Copland, Stokes, Watson, and even Trousseau still hold it. A host of other living writers have declared an opposite opinion—Pepper, Davies, Schuh, Skoda, Hamilton, Roe, Audouard, Willshire,* O'Flaherty in 1770, and Le Maire in 1735, in their *Inaugural Theses*, advised the operation, and I agree with the latter.

A recent writer, Dr. Gairdner, avoids "the sudden ingurgitation of air during inspiration," apparently not because of the irritating effect of the air, but to avoid the chance of its pressure upon the expanding lung. This is an imagined danger: I have frequently seen in the Crimea, the pleural cavity opened and the lung nevertheless remain in full action.

I believe it to be a groundless fear that a serous will be converted into a suppurative fluid by the operation of thoracentesis.

Pus is a formation from plastic exudations in a state of chronic inflammation. Now these plastic exudations will be more readily formed by the detention of an abnormal fluid, and a greater tendency to the formation of pus induced. The following queries arise: Does serum effused, from whatever cause, into a serous cavity, ever become pus, whether the cavity communicates with, or is shut off from the external air? Does the formation of pus in a serous cavity take place with equal readiness in a shut as in an open cavity? Upon a true solution of these queries will depend the procedure to be adopted in cases of thoracic effusion; for as we see, the main if not the only objection to paracentesis thoracis has been the fear that by the introduction of air into the cavity serum will be replaced by pus. Now, if it can be shown that this change can not occur, or if it does, that it may happen equally in a shut as in an open cavity, it will follow, *cæteri paribus*, that the fluid in a thoracic abscess is to be let out just as in any other abscess, such as pelvic cellulitis, etc., etc. Besides, from the observations of Wedl, we know the wonderful rapidity with which pus forms. We have therefore a most cogent reason for ejecting it from the system. "Two, three, four, and five nuclei have been produced from one pus corpuscle by the process of division; they separate from each other, the contents of the pus corpuscle sub-dividing into as many portions." We may now see how forcibly this fact will apply to the advocation of an early operation in cases of effusion, for he shows, "how necessary it is to eliminate, or destroy these corpuscles in order to prevent the formation of pus from pus." And this line of argument will apply also to serous effusions, for where there are any abnormal cells in effusions, it is hard to tell whether there may not be one solitary pus cell, which will soon go on generating its own. Besides there is

*See *Lancet* May 31, 1862.

no doubt that inflammation is increased by the continuance of an effusion in the pleural cavity, and that a proclivity to tubercular degeneration is engendered in the healthy lung, quite irrespective of the damage to the diseased side.

Another reply to the first query may be given in the words of Rokitansky, who doubts whether "a perfectly clear serous fluid can be attributed to actual inflammation," and if not to actual inflammation, pus can not occur. And Laennec says, "a hydrothorax is an accumulation of serum in the pleura, which otherwise is altogether healthy," and he nowhere infers that it ever becomes pus; but if ever it does become pus, a speedy outlet is the more required.

The reply to the second query is easily given. It is quite established by surgeons that pus will form as readily in a shut as in an open sac. There is therefore no increase of danger in making an opening, but a great increase of safety. Our increased knowledge of histology enables us to speak positively on this point. If anything more were required, the words of Wedl, as already given, would settle the question.

Has it ever been proved, by direct experiment or otherwise, that air is injurious to the serous membranes? For if it has not been shown that air is injurious, but proved that it is innocuous, the question is virtually settled, and the statement will rank among other notable medical facts, which Cullen, not over-politely, called "medical lies;" although this great man himself was not free from the *non causa pro causa*, as when he attempted to explain the *modus operandi* of salivation, by alleging that the "ammoniacal salts existing in the saliva have a peculiar tendency to run off by the salivary glands," whereas "no ammoniacal salts exist in the saliva!"

Nysten has shown by direct experiment that air is not injurious to the healthy pleura. Hewson blew air into the chest of a rabbit, and confined the air for some time with a bandage, but no harm arose for the animal was quite well in a few days. If the admission of air were so injurious its effects would no where be more marked than in wounds of the thorax, by producing all the dreaded effects, viz: pleuritis, and the consequent secretion of pus. Now in five instances of chest wound related by me* after respectively eight, thirteen, and seventeen days, and in three cases, three days, there was only a sero-sanguineous discharge.

But what becomes of this dread, if it can be shown that there is always air in the pleural cavity, and consequently any additional admission must be innocuous? The experiments of M. Ribes show that there is a certain amount of air in the normal pleural cavity, for in the operation of thoracentesis, "if the canula be left in, the trocar will be forced out by the pressure of air from within." This might happen though by the effect of actual pressure from the expanding in inspiration. Dr. Sedwick relates a case† in which air in abundance followed the introduction of the trocar." Rokitansky says, "In rare cases, a certain quantity of air is found in the pleural sac."

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* *Wounds of Chest.* †*Lancet* June 21, 1856.

Dr. Hales also, in his vegetable statics, has given two experiments, Nos. 112 and 113, which showed the pressure of air.

It has been asked, whether air can be present in the pleural cavity unless there be an opening between the cavity and the lung? That there may be I am certain, as verified by myself both in recorded* experiments and in actual cases. On the other hand, in 1744, Boerhaave and Haller satisfied themselves that there is no air in the normal pleura; and Lieberkühn alleged that he had proved the absence of air, by opening the chests of dogs under water. These last do not invalidate all the others; but if air were so injurious, it would cease to be so in the cases in question when the time came for the operation, for then the pleural covering is not in a normal condition.

The whole bearing of the question now tends to an operation in all ordinary cases. In my view there are very few exceptional cases; to these I shall refer by-and-by.

There is another point which is made more of than is necessary, whether the operation is to be deferred until the active stage of pleuritis has passed off? Of course, no one would propose to puncture the thorax during the early stage of the disease, *i. e.*, in the very acute stage, unless there were impending suffocation; but the period between the acme of the acute stage and the effusion of fluid is sharp and speedy. I saw a man who from injury had fractured ribs—he died a few hours after the accident, and at least a pint of serum was already in the right pleura; we have therefore little time for reflection.

If it be conceded that, as a rule, an operation is the best remedy, then the sooner it is performed the better for the patient; for the longer the operation is delayed, as shown in Case 9, p. 91, the larger become the evils, and smaller the hope of a successful issue. The lung becomes pressed by the fluid upward and backward upon the spinal column to such an extent in some cases, that it is related by Audouard, p. 5, at an *autopsy*, that the lung was declared by those present to be absent, and its remnants were asserted to be visible in the effused pus.

There is a fine instance of this extraordinary compression in the otherwise interesting Case 6, p. 87, supplied to me by Dr. Woodman.

Although the chances of the lung, when once bound down by false membrane re-expanding on the removal of the fluid, will be in proportion to the duration of the disease, still this is not to be placed as an impediment to the performance of the operation, because it is impossible to predicate to what extent the air may enter the air-cells and re-expand the lung in any one individual case; therefore the attempt ought always to be made. Cases 11, p. 93, and 12, p. 95, show this.

It is extraordinary the thickness to which the fibroid substance will attain —from a line to more than an inch; and we can now understand the small chance of the absorption of pus through a substance so dense and unabsorbing. There is another reason for an early operation, if the conjecture of Hope be correct, that pus may be removed by endosmose or exosmose from the

* *Wounds of the Chest.*

pleural cavity; this can happen only before the membrane has assumed a fibro-cellular tissue.

The following conditions are said to contra-indicate an operation:—

1. Tuberculosis of one or both lungs.
2. Bronchitis.
3. Diseases of the heart.
4. Any other organic disease.

As regards the first, it has been shown that the continuance of the fluid in the cavity of one pleura is sure to set up, if not already present, the action of tubercular deposit in the healthy lung, although this action may be restrained or stopped in the compressed lung in which only it was originally present. I must admit, however, that so far as the few statistics upon this point go they are unfavorable to the operation. Out of ten very interesting cases supplied to me by Dr. C. Tüngel, of Hamburgh, in which thoracentesis was performed, four were tubercular which all died.

2. Bronchitis is no bar, because if not already present, it is almost sure to begin in the healthy lung from the increased strain put upon it.

3. Diseases of the heart will not be precipitated by the operation, but are more likely to be benefited than injured.

Laennec operated in cases where a fistulous opening existed between the pleural cavity and the bronchial tube. A London surgeon has gone so far as to propose to puncture a tubercular cavity. I think this latter proposal objectionable. As for other organic diseases it is not the operation which kills but the disease, which would have killed under any circumstances; but the *post hoc ergo propter hoc* comes in nevertheless especially with the public, and the demise following the operation discredit is unfairly brought upon the procedure.

An operation having been determined upon we have to decide upon the place of puncture. The place most usually selected is between the fifth and sixth, or between the seventh and eighth intercostal spaces, a little anterior to the axillary region: any other point may be, according to the case, selected, for instance, it is well to remember that in some cases the lung is not pressed upward and backward, but forward, so that the chief collection of fluid will be found posteriorly, this condition may arise from the presence of pleural adhesions. We must also avoid wounding the intercostal artery, which lies in a small groove on the inner surface of the rib just above its lower margin: the puncture should be made, therefore, at the upper margin of the lower rib bounding the intercostal space selected. Those who dread the introduction of air, advise that the skin should be so drawn up that the position in which it would naturally lie at the upper margin of the rib bounding the intercostal space to be punctured, should be drawn to the lower margin of the upper rib, so that the skin in pulling it would flap-like prevent the ingress of air by covering the wound.

These precautions are unnecessary and the trocar may be passed directly through the skin and muscle into the pleural cavity.

If thought advisable, a grooved exploring needle, recommended by the late

Dr. Thomas Davies, may be previously introduced to ascertain whether the effusion be serum or pus.

In fortunate cases, such as Case 1, the fluid is not re-secreted, the lung re-expands, and a cure results.

Often, however, the fluid re-forms, and formerly repeated punctures were made always giving more or less relief, and in some after a time the formation of the fluid would spontaneously cease; lately, Chassaignac's plan for healing sinuses has been applied to cases of pleural effusions with remarkable success, under the title of "The drainage system." This proceeding is highly commended by Dr. Hamilton Roe and Dr. Fincham, both of whom recommend that the tube ought not to be removed until all secretion of fluid has ceased.

This practice, notwithstanding its simplicity and total absence from danger has hitherto not been sufficiently applied by the profession in cases of pleural effusions. An ordinary India rubber tube with several perforations through which the serum or pus may flow, is passed through the abscess or sinus. It is thus described by Mr. De Morgan in the *Medico-Chirurigical Transactions*, Vol. XLII., p. 245:—"A puncture with a trocar, or a simple incision, may be made into the cavity of the chest at the usual places, between the fifth and sixth, or sixth and seventh ribs, or, indeed, in any convenient situation. A firm long iron probe, somewhat bent, is then passed through the opening, and directed toward the lower and back part of the cavity, the lower the better. If the end of the probe be made to press against the sides of the thoracic walls, it can be felt from the outside through the intercostal spaces, though perhaps obscurely, owing to the thickness and toughness of the false membrane. An incision is made upon the end of the probe, and its end brought through the opening. A strong piece of silk thread is passed into the eye of the probe, and drawn through the two openings, and the drainage tube being firmly tied to one end is then drawn through by means of the silk. The ends of the tube are tied together, and the operation is completed." See Cases 7 and 10, pp. 89–92, in which the drainage system would have answered well.

The operator may be disappointed some times by no fluid flowing after a puncture has been made.

This may arise from the following causes:—

The lung may be adherent to the costal pleura by old adhesions. This may be generally ascertained beforehand.

The liver may be punctured if it ascends within the limits of the thoracic cavity, not likely in a case of effusion; but this condition may be easily ascertained.

The trocar striking against a rib from the sudden spasm of the intercostal muscles. In old cases the dense fibroid structure to be passed through is so resisting as to cause a timid operator, not fully alive to the obstruction, to pause in the necessary thrust. I have seen one such instance. The operation may be only partially successful, as the fluid may be shut into different compartments, so to speak, by pleural adhesions, or it may be lodged between

the lobes of the lungs, or between the lung and diaphragm. In the former more than one puncture would be required; in the case in which the fluid lay between the lobes of the lung an operation might be sanctioned by a very clever diagnosis; the other would be one of the exceptional cases, unless the fluid caused a tumor beyond the margin of the ribs.

The time required has prevented me taking out the statistics of the operation. So far as the twelve cases given in this paper go, it stands thus:—One case of cure by operation; one case of cure without operation; five dead after operation; five plus one (the case of Jackson not recorded), making six dead without operation. The balance is therefore in favor of the operation.

In regard to the prevalence of pleuritic effusion being more on any one side than the other, the only records I have found are from the experience of Dr. Rae, which showed seven to five for the left side. Hasse, in thirty-five cases, sixteen were on the left, ten on the right side, and nine in both. Mohr, in fifty-six cases—thirty-seven were on the left, nineteen on the right. Those given in this paper show twelve in the right, and one only in the left side. Dr. Rae reports that Valsalva and others had found the effusion most frequently in the left side.

Taking one only of the *post mortem* books of the Hospital, Dr. Woodman ascertained for me, that among four hundred *post mortem* examinations of all diseases and accidents, thirty had pleural effusions. Of twenty-seven of these, seven were on the right side, three on the left side, seventeen on both sides. The preponderance on both sides arises from the deaths having been caused by constitutional ailments, leaving the balance still in favor of the right side in acute thoracic diseases.

In conclusion, I refer to Laennec's masterly description of the distorting effects of these effusions upon the bony parietes of the thorax and spinal column, all which may be more or less mitigated by a successful operation, for then the expanding lung meets the parietes of the chest, and the otherwise inevitable deformity is arrested.

For the convenience of any one who may desire to examine the published cases, I subjoin the following list of those I have had at hand:

In a series of cases recorded in the *Medical Times* of January 7th, 14th, 28th, February 4th, 18th, we have twenty-five cases of recovery by absorption; six, recovery by evacuation through bronchial tubes; three by "empyema necessitatis;" one by evacuation into lungs.

Case by Wm. Sedgwick, *Lancet*, May 20, 1854.

Medical Times, January 28; do. p. 83; do. February 4, p. 108.

Dublin Quarterly Journal, vol. 28; seven successful cases by Mr. Smyly.

Cases by Dr. Pepper, in the January No. of 1852, *American Journal of Medical Science.*

Cases of Hope, Mohr, Rae.

Vol. 2nd, *Ed. Med.-Chir. Trans.*, p. 229, by Dr. Pitcairn.

No. 93, *Ed. Med. and Surg. Journal*, by Dr. Duncan, Jr.

Twelve cases related by the late Dr. Thomas Davies.

Lancet, May 6, 1851, p. 493.

Cases by Trosseau, *Clinique Medicale.*

REYNOLDS' SYSTEM OF MEDICINE.

The first volume of this great work is published in London, and has been received by our publishers, Robert Clarke & Co. The price of the English copy is fourteen dollars the volume. We have not learned whether it is to be republished. The following table of contents of the first volume will give some idea of its arrangement:

Influenza, by Edmund A. Parkes, M.D., F.R.S. Malarial Fevers, by W. C. Maclean, M.D. Diarrhœa, by Edward Goodeve, M.B. Dysentery, by W. C. Maclean, M.D. Epidemic Cholera, by Edward Goodeve, M.B. Pyæmia, by John Syer Bristowe, M.D. Parotitis, by Sidney Ringer, M.D. Croup, by William Squire, L.R.C.P. Lond. Hooping-Cough, by Edward Smith, M.D., F.R.S. Constitutional Syphilis, by Jonathan Hutchinson, F.R.C.S. The Plague, by Gavin Milroy, M.D. Scarlet Fever, by Samuel Jones Gee, M.D. Dengue, or Dandy Fever, by Wm. Aitken, M.D. Diphtheria, by William Squire, L.R.C.P. Measles, by Sidney Ringer, M.D. Roseola, by Hermann Beigel, M.D. Small-Pox, by J. F. Marson. Vaccination, by Edward Cator Seaton, M.D. Varicella, or Chicken-Pox, by S. J. Gee, M.D. Typhus Fever, by George Buchanan, M.D. Enteric or Typhoid Fever, by John Harley, M.D. Relapsing Fever, by J. Warburton Begbie, M. D. Yellow Fever, by J. Denis Macdonald, F.R.S. Erysipelas, by J. Russell Reynolds, M.D. Equina, or Glanders, by J. Gamgee & A. Gamgee, M.D. Hydrophobia, by J. Gamgee & A. Gamgee, M.D. Sudamina and Miliaria, by Sidney Ringer, M.D. Purburer, by Thomas Hillier, M.D. Scorbutus, or Scurvy, by Thos. Buzzard, M.D. Rickets, by W. Aitken, M.D. Gout, by Alfred Baring Garrod, M.D., F.R.S. Rheumatoid Arthritis, by A. B. Garrod, M.D., F.R.S. Rheumatism, by A. B. Garrod, M.D., F.R.S. Gonorrhœal Rheumatism, by B. E. Brodhurst, F.R.C.S.

The *London Lancet*, May 19th, thus concludes its notice of this great work: "We have done our best to convey a fair estimate of the scientific worth of the articles. In the minor points of style and interesting arrangement of matter, though the editor is always faultless, a few of his contributors are rather provokingly careless or uncultivated. If this be an unavoidable reflection on reading a few of the articles, the editor may comfort himself with the assurance that, in all human probability, so large a staff of medical writers as those who have produced this volume never existed at once on the habitable globe, of whom a notable proportion were not quite unskilled in literary expression, however good they might be in science."

AMERICAN MEDICAL ASSOCIATION.*

First Day—*May* 1.

The Seventeenth Annual Meeting of the American Medical Association was held in the city of Baltimore, at Concordia Hall. The Association was called to order, at 11 A. M., Tuesday, May 1st, by the President, Dr. D. Humphreys Storer, of Boston.

Dr. C. C. Cox, on behalf of the Committee of Arrangements, in the opening address, gave a warm welcome to the Association, and hoped that when the short stay of the members was ended, they would have cause to retain kindly remembrances of the Monumental City.

THE CASE OF DR. MONTROSE A. PALLEN.

Dr. Cox offered certain documents exculpating Dr. M. A. Pallen, of Missouri, from the charges brought against him at the meeting in Boston, and for which he was then expelled. On motion of Dr. Cox, the papers were referred to the Committee on Medical Ethics, with a request that they report promptly.

Subsequently, Dr. Hooker, Chairman of the Committee on Ethics, presented the following report, which, after being warmly discussed by Drs. Owens and Bond of Maryland, and Tyler of Washington, was finally adopted:

"The committee, to whom were referred the papers in relation to the expulsion of Dr. Montrose A. Pallen, at the meeting of the Association in Boston, respectfully report: That they have examined the documents and evidence referred to the committee, embracing papers indorsed by General U. S. Grant, the Vice-Consul of the United States at Montreal, and many citizens of Missouri, and are fully satisfied that the statements on which his expulsion was based were entirely unfounded; and, therefore, regretting the injustice done, both to Dr. Pallen and the Association, we recommend the following resolution:

"*Resolved*, That the preamble and resolution adopted by the Association at its annual meeting in Boston, June, 1865, expelling Dr. Pallen, be hereby rescinded; and that Dr. Montrose A. Pallen be restored to his previous membership in the Association."

On motion of Dr. Ordway, a committee of three was appointed, to wait upon Dr. Pallen, and inform him of the action taken in his case; and on motion of Dr. Owens, Dr. Cox was made chairman of said committee.

Dr. Pallen was then presented to the Association, and thanked them in an appropriate and feeling manner for the action they had taken in regard to his case.

THE PRESIDENT'S ADDRESS.

Dr. D. Humphreys Storer, the President, followed with his annual address. His subject was that of Specialties in Medicine. The ground which he took

* This report has been condensed from that given in the *Medical Record*.

was one of encouragement to all such worthy and qualified young men as chose to confine their particular attention to one branch. The address was a well-written and interesting one, and commanded the most respectful attention of all present.

On motion of Dr. Holton, of Vermont, the thanks of the Association were tendered to the President, and the address was referred to the Committee on Publication.

The reports of special committees were then called for, and all the papers that were presented were referred to appropriate sections.

The following voluntary papers were then in turn offered, and in like manner referred: "On Luxation of the Hip-Joint, nine months' standing, etc.," by Dr. L. A. Sayre, of N. Y. "On Improvements in Water-Pipes," by Dr. J. C. Draper, N. Y. "On Extirpation of the Uterus," by Dr. H. R. Storer, of Boston. "On Permanganate of Potassa as a Purifier," by Dr. Craig, of D. C. "On the Application of Local Anæsthesia to Practical Medicine," by Dr. J. Solis Cohen, of Philadelphia. "On Aluminum in Dentistry," by Dr. Mason, of Mass.; and "On Exsection of Lower Jaw," by Dr. D. C. Enas, New York.

On motion of Dr. Cox, Dr. E. Brown-Séquard was invited to deliver a lecture before the Association, upon the treatment of nervous diseases, at 11 A. M., on Wednesday.

On motion of Dr. Davis (Ill.), Dr. H. Marsden, of Quebec, was elected a member by invitation, and invited to a seat upon the platform.

The meeting then adjourned to meet at 9 A. M., on Wednesday.

SECOND DAY.—*May* 2.

The Association was called to order by the President, Dr. D. H. Storer, at 9 A. M.

The Committee on Epidemics, Meteorology, etc., having been called upon, Dr. Davis stated that Dr. Hamill had presented a report which he had taken to the section on Epidemics, etc.

THE NOMINATING COMMITTEE.

The following members were announced, as constituting the Nominating Committee: J. C. Weston, Me.; J. C. Eastman, N. H.; Wm. McCollim, Vt.; J. R. Bronson, Mass.; D. King, R. I.; W. Woodruff, Conn.; J. C. Hutchinson, N. Y.; W. Pierson, jr., N. J.; H. F. Asken, Del.; John L. Atlee, Pa.; J. J. Cockrill, Md.; M. A. Pallen, Mo.; N. S. Davis, Ill.: W. Lockhart, Ind.; J. M. Withercone, Iowa; N. R. Bozeman, Ala.; C. M. Stockwell, Mich.; H. Van Dusen, Wis.; T. A. Atchison, Tenn.; G. Fries, Ohio; G. Tyler, D. C.; W. M. Charters, Geo.; J. Simpson, U. S. A.; N. Pinkney, U. S. N.; Greeneville oDwell, Texas.

Dr. W. Hooker offered the following resolution, which was unanimously adopted:

"*Resolved*, That no report or other paper shall be presented to this Association, unless it is so prepared that it can be put at once into the hands of the Secretary, to be transmitted to the Committee on Publication."

Dr. Wistar, of Pa., offered the following, which was adopted:

"*Resolved*, That Drs. Grafton Tyler, W. P. Johnson, and James M. Toner, of D. C., be a committee to procure a room in the Smithsonian Institution, for the preservation of the archives of the Association."

The Committee on Medical Education not having prepared a report, Dr. J. F. Hibberd offered instead thereof the following preamble and resolution, and moved that it be adopted as the sentiment of the Association:

"WHEREAS, Two-thirds of the Medical Colleges of the States of Ohio, Michigan, Illinois, Iowa, Missouri, Kentucky, and Tennessee, by delegates in convention assembled in Cincinnati on the 24th of April ult., did, by resolution unanimously adopted, declare their willingness to make their annual college sessions to continue for six months, and to establish an uniform rate of fees, if the other principal colleges of the country will co-operate; now, therefore,

"*Resolved*, That the American Medical Association hereby expresses its warmest approbation of the action of the above-recited colleges, and expresses the hope that every Medical College in the Union will concur in the proposition thus made."

On motion of Dr. Taylor, of Iowa, its consideration was postponed till 11 A. M. on Thursday, to be acted upon in Committee of the Whole.

Dr. C. A. Lee, of N. Y., commenced reading his report upon Medical Literature. He divided his subject as follows: 1. Periodical Medical Press; 2. Medical Literature of the War; 3. Literature of the Sanitary Commission and of Sanitary Sciences; 4. State and County Society Transactions; 5. Literature of Special Subjects and of Specialties; 6. Literature of Pharmacy and Materia Medica; 7. Of Vital Statistics; 8. Of Life Assurances; 9. And of Introductory Lectures.

He was interrupted at eleven for the regular order of business, which was the lecture of Dr. Brown-Séquard, on the Treatment of Functional and Organic Diseases of the Nerves.

On motion of Dr. Raphael, of N. Y., the thanks of the Association were tendered to Dr. Brown-Séquard, for his interesting, able and eminently practical lecture, and he was requested to furnish an abstract for publication.

Dr. C. A. Lee then resumed the reading of his reports. After this had continued for some time, on motion of Dr. Toner, the further reading was discontinued, and the paper referred to the Committee on Publication.

Dr. Gross, chairman of the Committee on Medical Education, reported that he had not prepared a report, and asked that the committee be discharged which was granted.

REPORT OF PRIZE COMMITTEE.

Dr. E. Elliot, secretary of the Committee on Prize Essays, read the report of that committee.

On breaking the seals, Dr. W. F. Thomas, of New York City, was ascertained to be the author of the "Essay on Health in Cities," etc., and was entitled to the first prize; and Dr. S. R. Percy, of N. Y., on "Digitalin," etc., to the second.

On motion, the paper on Angular Curvature of the Spine was referred to the section on Surgery.

The report of the Committee on Medical Ethics having been offered, it was made the special business for 9:30 on Thursday.

Dr. Marsden, of Canada, having been announced as desirous of making some remarks on Cholera—

On motion, it was agreed that he should follow immediately after the report on Medical Ethics.

Dr. Cohen offered a paper on Paralysis of the Vocal Chords and Aphonia, etc.; referred to the section on Surgery.

Dr. H. R. Storer offered a paper on the "Clamp Shield," an instrument designed to lessen the dangers of extirpation of the uterus by abdominal section.

Dr. Bozeman, of Ala., was introduced to the Association, and, on motion of Dr. Holton, he was made the member of the Committee on Nominations, for Alabama.

Dr. J. C. Hughes, of Iowa, offered a paper on Lithotomy, which was referred to the section on Surgery.

Dr. Taylor, of Iowa, introduced a resolution for the appointment by the President of the Association of a member from each State, to memorialize Congress for an appropriation to publish the reports and documents of the Surgeon-General of the United States.

Dr. Pallen recommended that the reports and documents of the like character connected with the rebel army, be also referred to the same committee for access to the same.

Dr. Pallen, after some discussion, withdrew his amendment.

The original motion was carried.

THIRD DAY.—*May* 3.

The Association was called to order, at 9 A. M., by the President; after which, the announcement of the members of the Committee to Memorialize Congress on the Publication of the Surgical History of the War, was made.

Dr. C. C. Cox, of the Committee on Necrology, reported progress, and, on motion of Dr. Hibberd, permission was given the reporter to send the report when ready to the Committee on Publication.

Dr. J. S. King, of Natchez, Miss., forwarded a communication to the Association, stating that he was engaged in the compilation of the mortuary and similar statistics of the principal cities and towns of the country, and requesting that physicians would transmit to him such information upon those subjects as they could gather in their respective localities.

The Secretary read a communication from the Dubuque (Iowa) Medical Society, requesting the erasure of the name of Dr. Asa Horr.

On motion of Dr. Jewell, the request was granted.

[*Concluded in the next Number.*]

MISCELLANY.

Duties of the Practitioner to the Dying.

In our last number we endeavored to show the unpleasant impression made by some members of our profession, when they presume to tell patients that their days are numbered, and when patients dare to live on and get well in spite of the prophecy. There can be but few of our readers who are not acquainted with some case or other which has been too hastily condemned in consequence of cavity in lung, or imperfect valves of heart, or albumen in urine. We speak not merely of gloomy anticipations, which have not been realized—nor yet merely of suspicions of danger, plainly, yet cautiously intimated to the patient or to his family; but we speak of positive, peremptory statements that Mr. A or Mr. B can not live six weeks, or whatever the term Dr. Rhadamanthus may be pleased to allow. Of course, patients so sentenced give up their faith in the profession, and lend a willing ear to any quack who may promise them relief. Nor is this to be wondered at. It is a serious injury to the profession, but one for which the profession itself is to blame.

But the whole question involved is a very serious one; and as we write for men whose avocations are daily exposing them to the possibility of error, we make no apology for taking up a few moments of their time in discussing the right principles of action under certain circumstances.

In the first place, we are bound to set before us, in its fullest extent, the idea of Life as the most precious of all gifts of the Creator. It is the gift which includes all others. It is, so far as we know, the only opportunity which man has of improving his own moral being, or of contributing to the carrying out the designs of the Creator. No life whatever can be set at nought, nor can we venture to call it of no possible service. Life, therefore, is to be upheld, maintained, struggled for under all circumstances, by the practitioner of medicine; and it is his very first duty to avoid all things which may shorten it even for an hour.

Equally is it the duty of the patient himself to cling to life with the most unflinching purpose. It is his time of work and improvement: and, till all possible work is done, and all further moral improvement impossible; till the body has reached the term of natural decay; till all the duties of life are accomplished, we hold that to desire death, or not to desire life ardently, and not to take every rational means of prolonging it, is an offense against religion and nature. The fear of death, and love of life are implanted in our bosoms, like all the other instincts, for the wisest purposes.

Here we must bestow a passing word of condemnation upon that prevalent idea of the peculiar sanctity of early death—the detestable and unnatural notion that consumption, for instance, is *la mort des élus*, the fate of those whom the Almighty regards with his most especial favor. All the analogies

of heaven and earth cry out against a doctrine so shocking. Work—work, inward and outward; work in subduing his own passions; work in subjugating the earth to the use of man; work in the rearing of a succeeding generation, and in promoting the improvement of the human race; this is the real lot of man, and he is most blessed whose lot is in this respect the richest. But in what we say, do not let us be understood as denying the "sweet uses of adversity." Some there are to whom Providence has denied active work, and yet whose example of suffering patiently the loss of health and of all the enjoyments of youth, is felt as a most blessed influence upon all around them. Meekness in suffering is exquisite; but yet the great ends of our being are and must be carried on by the work of the strong and healthy. To resign life without a murmur is good; to employ it actively is better. View it in what aspect you will, it is life which is our most precious possession; resign it we must, without a murmur, when called on; but to despise or throw it away, or not to desire to keep it, is a sacrilege. *Vivens! vivens! ipse confitebitur Tibi* is the soul of the *religio medici*.

Holding life, then, in this most sacred light, we are prepared to lay down the exact motives which should influence the practitioner, when it is in danger, or supposed to be so.

For example: we believe that it is a positive duty, never to be neglected, to remind the patient, or those about him (if a reminder is necessary) of the expediency of availing himself to the utmost of the consolations and offices of religion. But this should not be done merely because the patient is likely to die, but simply because, being ill, he can not seek the offices of religion in public; because he has time to attend to them, and requires the comfort they afford; and more especially because they afford the means of living on—if life be spared—more usefully and happily. We repeat, that religious offices should never be degraded into mere nostrums for the dying; the clergyman coming when the physician gives up the case; as the ancients put money into the mouths of the dead to propitiate the ferryman of Hades; but they should be resorted to as means of better life; as the daily bread of the living, and not merely as the viaticum of the departing.

So let us imagine the case of a person ill, or hopelessly ill. It is the duty of the physician still to adopt every means for his benefit. But is he to inform the patient in every case that there is little or no hope?

We can conceive that such a course is justifiable if the patient willfully and recklessly neglect to settle his worldly affairs, or persists in a course of profligacy and wickedness. Scarcely otherwise

"Gravi me terrore pulsas, vitæ dies ultima."

So said a poet, with whom our readers ought to be acquainted, and so says human nature. To tell a man that he must be cut off, inflicts a pang sharper than that of the knife, and it should not be done unless some great end is to be attained. We are not meaning to imply that the physician is to conceal *danger* from the patient's friends, or to state anything positively untrue; but we do say, that his paramount duty of preserving life to the utmost may render it imperative on him not always to tell the whole truth to the patient,

if, by so doing, he lessens by one jot or tittle the chances of his recovery. For our own part, we should always desire to know if our own life were in jeopardy, and should feel bound to give the same information to any patient who desired it, and was able to view the matter in its proper light. But there are many to whom such an announcement would be dangerous and unjustifiable.—*Times and Gazette, Nov.* 1855.

"*Observations sur l'insuffisance du Service de Santé en Campagne*, page 398, § IX." (*Rapport au Conseil de Santé des Armées, pendant la Campagne d' Orient en* 1854–5–6, *par J. C. Chéme.* Paris, 1865).

M. Elisée Reclus has published, in the *Revue des Deux Mondes*, a splendid picture of American philanthropy; but is it in any of our European states that a sanitary commission would have the foolish, criminal thought of saying to a minister of war, "*We are firmly and wholly resolved to furnish those men who fight for their country with those comforts which are their due, and which the nation has the will and the duty to afford them. Whether the government interferes or not, we will give them those comforts in spite of all!*" It is in our armies that certain members of a philantropic society "*would largely make use of the right, which all the Yankees have taken to themselves, of questioning to any extent, and would make officers of regiments answer certain regulated examinations, uniformly composed of five hundred questions, and would forward the result of all their answers, with their own private observations, in a report addressed to the central commission?*"

Is it in our armies that *volunteer services would be forced on and act with regular services?* All this shows a great disorder in the American Army, and fortunately we have not gone so far. If there is yet much to be done to better the condition of the wounded and sick of European armies, it must be said that the intervention of a philanthropic society never would have found an opportunity of acting in presence of such disasters. We do not understand how forty medical men, sent by the Sanitary Commission to Sharpsburg, could have arrived on the field of battle three days before the medical men of the ambulances and the wagons sent by government; with us, this would look like treason.

We better understand the hospital ships which the Commission sent to York River to relieve the Chickahominy wounded, and no country would refuse such valuable help, due to a provident public charity. If we had had well organized hospital ships in the bay of Kamiesch, it is certain we would have made profitable use of them.

The admission of volunteer civil element would but produce disorders of more than one kind. What happened in America? The sanitary commissions invaded the greater portion of the services; they took to themselves the control, they made reports, and soon acted as an independent power; they had better information than government itself; the papers published their correspondence whether true, exaggerated, or false, etc. This could not but happen where interference is subject to army discipline; America alone could allow such eccentricities.

But what we do admire, and what could prove useful as an example, is the patriotism of the American ladies, and the voluntary contributions collected by different charitable societies of the United States, which contributions surpass in importance the duties collected in more than a kingdom of Europe; for, since the commencement of the war to the 1st of March, 1864, they amounted, it is said, to over 228 million of dollars. Therefore we will say, with M. Réclus, is there a country in the world where citizens have a more active generosity, and a stronger feeling of duty toward their country?

Death of Dr. Mussey—Action of the Medical Profession.

A meeting of the medical profession of Cincinnati was held at the Medical College of Ohio, June 29, 1866.

Dr. George C. Blackman stated the object of the meeting was to express the deep felt sentiments of the profession of this city in reference to the death of the late Reuben D. Mussey; whereupon Dr. David Judkins was elected President, and Dr. Samuel Sexton, Secretary of the meeting.

On motion a committee of five, consisting of Drs. John A. Murphy, George C. Blackman, M. B. Wright, John Davis and Jesse P. Judkins, were appointed to prepare a preamble and resolutions, expressive of the sense of the meeting. The following were then presented and adopted:

Whereas, In the providence of God our distinguished friend and brother, Dr. R. D. Mussey, has been removed to another world, we express our deep sense of sorrow. For more than fifty years he was a successful surgeon and physician, and a benefactor to humanity. He added greatly to the progress of the art and science of medicine. Equally distinguished as a physician and surgeon, his whole life was characterized by the highest sense of moral duty, and in all relations professional and social, uprightness and purity of motive and action characterized him. Few men have passed in the profession a better or more useful life. To labor, with him, was a duty, and to do good, especially to the poor, was his highest pleasure.

"To many of us he was almost a father, who not only by his sound medical teaching, but the kind and tender interest, the sober advice, and the correct life, taught us to love him, and to imitate him in all his good works. Known throughout this country, as well as in Europe, his loss will be regretted by all; therefore, be it

"*Resolved*, That in the death of Dr. Mussey the profession of Cincinnati has lost a father, a great surgeon and physician, the city a good man, and humanity a true friend.

"*Resolved*, That a copy of this preamble and resolutions be forwarded to the family by the Secretary, with the sympathy of this meeting in their grief."

Dr. Murphy embraced the occasion to express the deep feeling he had, in view of the death of so distinguished a man. He dwelt upon his character as a safe and judicious surgeon, his uniform kindness, professionally, to both rich and poor. He mentioned several incidents illustrating his truthfulness and honesty of action. That, although he continued in the profession until he

reached an age beyond that usually allotted to those engaged in so arduous a mode of life, yet he was still young in his appreciation of the progressiveness of surgery and its collateral sciences.

Dr. J. P. Judkins, who was Demonstrator of Anatomy in the Ohio Medical College when Dr. Mussey took the Chair of Surgery, referred, in remarks of much interest, to many traits of deceased's character; to his constant efforts to do good and elevate his fellows; his exemplary life. He never had forgotten many of the wise precepts in surgery, medicine, and morals impressed upon him in earlier days by Dr. Mussey. Dr. Judkins' remarks were of an exceeding interesting character.

Dr. Geo. C. Blackman, who succeeded Dr. Mussey in the Chair of Surgery in the Ohio Medical College, wished to pay his tribute of respect to the memory of this great surgeon. He extolled Dr. Mussey for his brilliant surgical career, for his operative ability as well as his contributions to the surgical and medical literature of his day. He prominently brought before the profession several capital operations not before generally adopted,—as his operation of ligating both primitive carotid arteries in the same patient, thereby cutting off the great source of supply of blood to the brain, the patient recovering from the effects of the operation, and living to justify that bold practice. This gave faith to surgeons in America in this operation, and placed them in advance of their Continental brethren. Dr. Blackman mentioned a number of brilliant operations of the deceased, which combined to give him that distinguished reputation abroad which he enjoyed.

Mr. M. P. Wright, although he did not feel that he could add any thing to what had been said, spoke of their intercourse having commenced in 1838, as colleagues of the Medical College of Ohio.

Dr. W. spoke glowingly of the many great traits of the deceased, and finished his remarks by relating his consultation with Dr. Mussey in his great original operation for the removal of the arm, including its attachments of scapula and clavicle.

Dr. David Judkins, the President of the meeting, made a few touching remarks concerning his relations with Dr. M., which were of long duration and of an intimate character. He referred to his intense love of truth—his geniality of manner when approached by men younger than himself in the profession—his devotion to the cause of Christianity—and concluded by saying that in the death of Dr. M., the profession and the world had met with signal loss.

It was resolved by the meeting to attend the funeral in a body. The meeting was the largest and most respectable of any of the kind held in this city for many years, attesting to the high professional esteem in which the deceased was held by the medical profession. Before adjourning Dr. George C. Blackman was appointed to prepare and deliver before the profession and others, at his earliest convenience, an address on the life and services of Dr. Reuben D. Mussey.

DAVID JUDKINS, *President.*

Samuel Sexton, *Secretary.*

A special meeting of the Cincinnati Academy of Medicine was also called, and appropriate remarks were made, and resolutions adopted. We are sorry to add that the vacant pews at the church at the time of the funeral service, and the slim procession to the grave, were sadly in contrast with what was justly due to the solemn occasion. We have long felt that the Queen City is far behind her sister cities in paying the last rites to those with whom, during life, they have been intimately associated.

Medical College of Ohio.

The attention of our readers is directed to the annual announcement of the above Institution. For particulars respecting the workings of its Didactic and Clinical departments, we refer to the circular which we have just been remitted to read.

The organization of the school was founded, in part, upon its Clinical advantages,—and these advantages have been greatly increased to students as the profession and people have become more and more impressed with their great importance. By a comparison of Surgical Clinics published in the recent circular of an Eastern school, whose reputation rests on "its Hospital advantages," with the operations performed by Prof. Blackman, before his class, we find the latter to be greatly in excess, consequently of superior advantages to students and medical men who may be deficient of surgical skill. The time for delivering Clinics and performing operations in the more private hospital, will be so selected as not to interfere with the days or hours devoted to Clinics in the public or Commercial hospital.

The following epigram, relating to the baronetcy conferred upon Sir William Ferguson, in recognition of his distinguished surgical services, is from the pen of an accomplished scholar. It is very happy in its allusion to the "bloodied hand:"

Vulnere Beatus.

Egregium arte suâ chirurgum nuper honare
Regina ut voluit condecosare novo,
"Vulnare quum ægrotos tot fecerit ille beatos,
"Sanguinis insigni nobilitatus erit:
"Sit Baronettus," aèt; Gentis Gestamen avitum
Augeat huic post hoc sanguinolenta manus!

London Lancet, May 19th.

M. Nelaton has been appointed Surgeon in Ordinary to the Emperor, *vice* M. Jobert de Lamballe, whose recovery from the attack of insanity with which he was seized last fall is now despaired of.—*Illust. London News*, June 2.

That excellent Monthly, *The Nashville Journal of Medicine and Surgery*, we are glad to learn, is about to be revived under the editorial management of Drs. Bowling and Eve, the former being editor and proprietor. The Journal formerly had, as it deserved, a very extensive circulation, and, with its able editorial staff, must soon regain its former position. We quote from the prospectus the following: "As to the editing, we feel ourself better quali-

fied now than when we conducted the old series. We have, we hope, a good deal of unexpended force and grit in us, which, with a modicum of enthusiasm and worldly prudence might be made available for good. We do not desire to make any money by the Journal, and if we did we have experience enough to know that we could not do it, but we hope to be useful to our generation. In every case, without exception, the Journal must be paid-for in advance. This is not to be regarded as questioning the ability or willingness of the late subscribers to pay for it—not at all. When the subscription expires he is no longer a subscriber,—and delicacy would suggest the impropriety of teasing him into a renewal of his subscription by forwarding him the Journal." The first number was announced for the first of July. Terms $5 per annum.

MEDICAL COLLEGE OF OHIO.

ANNUAL ANNOUNCEMENT FOR 1866-7.

The *preliminary* Lectures in this Institution will commence Oct. 1st, and the Regular Term Oct. 15th—ending March 1st.

FACULTY.

GEORGE C. BLACKMAN, M. D.,
Professor of Principles and Practice of Surgery and Clinical Surgery.

JAMES GRAHAM, M. D.,
Professor of the Theory and Practice of Medicine.

M. B. WRIGHT, M. D.,
Professor of Obstetrics and Diseases of Women and Children.

C. G. COMEGYS, M. D.,
Professor of the Institutes of Medicine and Clinical Medicine.

THEOPHILUS PARVIN, M. D.,
Professor of Materia Medica and Therapeutics.

W. H. GOBRECHT, M. D.,
Professor of Anatomy.

ROBERTS BARTHOLOW, M. D.
Professor of Physics and Medical Chemistry.

W. W. SEELY,
Professor of Diseases of the Eye and Ear.

SAMUEL NICKELS, M. D.,
Demonstrator of Anatomy.

C. O. WRIGHT, M. D.,
Prosector to Professor of Anatomy.

Fees for Professor's Tickets, $40.00.

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